



DATE OF REVIEW: January 28, 2011

IRO Case #:

Description of the services in dispute:

EMG/NCV Bilateral Lower Extremities (#95861, #95900)

A description of the qualifications for each physician or other health care provider who reviewed the decision:

The physician who provided this review is board certified by the American Osteopathic Board of Surgery in Neurological Surgery. This reviewer is a member of the American Osteopathic Association, the American College of Osteopathic Surgeons, the Texas Osteopathic Medical Association and the Texas Medical Association. This reviewer has been in active practice since 1995.

Review Outcome:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be upheld. EMG/NCV of the bilateral lower extremities (#95861, #95900) is not medically necessary.

Information provided to the IRO for review:

Patient clinical history [summary]:

The claimant is a male who is reported to have sustained injuries to his low back on xx/xx/xx. Records indicate the claimant has a pre-injury history of microdiscectomy performed in 1985. As a result of the workplace injury the claimant underwent a fusion at L3-4 and L5-S1 in 1994. The submitted clinical records indicate the claimant subsequently has developed postlaminectomy syndrome and has been under the care of Dr. for a number of years. The information submitted indicates the claimant continues to have low back pain and left leg radicular pain in both L5 and S1 distributions. Dr. has provided pain management. Clinical records from Dr. indicate the claimant had limited lumbar range of motion. He has positive straight leg raise, resulting in radiation of L5 and S1 distributions at less than 45 degrees. He is noted to have serially decreased sensation in the left L5-S1 distributions.

The most recent clinic note by Dr. dated 01/29/10 indicates the claimant suffers from intractable back and leg pain secondary to herniated disc sustained as a result of the job related injury. He later underwent laminectomy and fusion. He has undergone multiple injections and physical therapy, which helped but did not provide long term relief. He continues to have low back pain. The claimant has severe radicular leg pain and was referred back to Dr., who agreed the claimant would most likely require another surgery. Examination indicated straight leg raise was markedly positive

low back as a result of lifting on xx/xx/xx. The submitted clinical records indicate the claimant on the left with some patchy numbness noted in the S1 distribution. Records indicate that Dr. subsequently moved his practice to the area, and the claimant was referred to Dr..

On xx/xx/xx the claimant presented to Dr. and is reported to have sustained an injury to his low back while moving a metal rack. He later underwent fusion at L3-4 and L5-S1 in 1994 and improved. Three years later he started to develop low back pain again. He had an MRI, which showed failed fusion at L5-S1. He tried not to have more surgery. He subsequently was seeing Dr. for pain management for the past 15 years. He reports constant low back and left leg pain rated as 6/10 with medications. He has aching in the low back, and pain radiates down his left leg. He reports stabbing, burning and numbness in left leg and left toes. This is increased with sitting, standing and walking. His leg pain is reported to be greater than back pain. Current medications well developed and well nourished. He complains of low back and left leg pain. The low back is nontender to palpation. Gait, heel and toe walking is normal. He has a well-healed midline lumbar scar. Range of motion of the lumbar spine reveals flexion to 45 degrees, extension to 5 degrees, which produces low back pain, and lateral bending 5 degrees to the left and to the right. Straight leg raise on left at 40 degrees produces low back pain and left leg pain. Motor exam reveals 5/5 strength in all lower extremity muscle groups. Sensory exam reveals hyperesthesia to pin over the left foot. Reflexes are diminished at the left ankle. Dr. subsequently recommended the claimant undergo EMG/NCV of the lower extremities to evaluate S1 radiculopathy and left leg pain. He provided the claimant with oral medications.

On 12/11/10 Dr. submitted a letter of appeal. He reports the claimant was first evaluated on 11/22/10 and complains of low back and left leg pain. He notes the claimant is status post fusion at L3-4 and L5-S1 performed in 1994. This helped for 3 years, and his pain subsequently returned. He has been under the care of Dr., pain management. On physical examination he is noted to have diminished left ankle reflex. Straight leg raise on the left at 40 degrees produced low back and left leg pain. Dr. reports because of continued pain and positive findings on physical examination he requested EMG/NCV of the lower extremities to look for axonal loss and denervation. He reports it is not clear if the patient's radicular symptoms are due to chronic changes and nerve damage or a more active problem. He subsequently requests appeal.

The initial review of the request was performed on 12/07/10. The review denied the request for EMG/NCV of the bilateral lower extremities, noting the claimant has a prior surgical history to include lumbar spine fusion. Imaging studies indicate the claimant has evidence of pseudoarthrosis at prior fusion site. The claimant has been noted to be unresponsive to previous treatment. He has obvious neurologic deficits on most recent physical examination. He subsequently notes that ODG does not recommend NCV studies for diagnosis of lumbar radiculopathy and does not recommend EMG studies when lumbar radiculopathy is already clinically obvious.

The case was reviewed on appeal on 12/28/10. The review notes positive physical examination findings and indicates that ODG only recommends EMG/NCV study when the claimant has undergone at least one month of conservative treatment and when radiculopathy findings are not clinically obvious. He notes that evidence-based guidelines do not recommend NCV studies. He reports the claimant's functional deficits do not warrant going outside guideline recommendations.

low back as a result of lifting on xx/xx/xx. The submitted clinical records indicate the claimant

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision:

The prior denials are upheld. EMG/NCV of the bilateral lower extremities (#95861, #95900) is not medically necessary. The submitted clinical records indicate the claimant sustained an injury to his ultimately underwent lumbar fusion in 1994. Postoperatively the claimant had 3 years of relief and subsequently developed recurrent low back pain with radiation into the left lower extremity documented on multiple clinical records as being in the L5 and S1 distribution. Serial records from Dr. indicate that the condition is chronic and not acute. It is further noted that most recent physical examination by Dr. on 11/22/10 clearly indicates the claimant has continued radicular symptoms in the left lower extremity with positive straight leg raise and sensory abnormalities. Given that the clinical records clearly indicate the claimant has left lower extremity radiculopathy, EMG/NCV studies would not be supported by ODG guidelines. The presence of radiculopathy is clinically obvious. Based on the totality of the historical record and available data, the previous denials are upheld and appropriate based on ODG guidelines.

A description and the source of the screening criteria or other clinical basis used to make the decision:

2010 Official Disability Guidelines, 15th edition, The Work Loss Data Institute. Online edition.