

Notice of Independent Review Decision

DATE OF REVIEW:

02/14/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

NCV/EMG bilateral lower extremities (BLE)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified Chiropractor

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: **Overtuned**

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The medical necessity for the requested procedure, bilateral lower extremities NCV/EMG, is established upon review of the documentation.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

Records indicate that the above captioned individual is a xx year old male who was allegedly injured as a result of an occupational incident that reportedly occurred on or about xx/xx/xxxx.

The history reveals that he had a dolly roll onto the top of his foot and he fell and as a result injured his low back, foot, knee, shoulder and head. He has undergone a litany of care to include ER management, chiropractic management and pain management. MRI examination of the lumbar spine dated 11/30/2010 revealed multilevel disc bulging from L2-S1 with no radiographic evidence of mass effect. Examination reveals normal reflexes, positive orthopedic testing, and complaints of paresthesias in the lower extremities.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The records reveal that the injured individual has subjective complaints of paresthesias. Additionally, the records reveal positive orthopedic testing such as positive straight leg raise (SLR) and positive Valsalva. Moreover, the clinical records document sensation changes in the bilateral lower extremities via pinwheel examination. The MRI findings are somewhat equivocal given the multilevel disc changes but no mention of mass effect or mensuration. The requested neurodiagnostic testing

can provide clinical correlation to the observed objective findings and reported subjective symptomatology.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Electrodiagnostic studies (EDS) See also Nerve conduction studies (NCS) and EMGs (EMG). Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. For more information and references, see the Carpal Tunnel Syndrome Chapter. Below are the Minimum Standards from that chapter.

Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards:

- (1) EDX testing should be medically indicated.
 - (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for “screening purposes” rather than diagnosis are not acceptable.
 - (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis.
 - (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed.
 - (5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted.
 - (6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression.
 - (7) In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009)
- EMGs (electromyography) Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. (Bigos, 1999) (Ortiz-Corredor, 2003) (Haig, 2005) No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. (Dimopoulos, 2004) EMG's may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA, 2001) (Note: Needle EMG and H-reflex tests are recommended, but Surface EMG and F-wave tests are not very specific and therefore are not recommended.