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Notice of Independent Review Decision

DATE OF REVIEW: January 17, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV bilateral lower extremities

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

Doctor of Chiropractic

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office visits (05/12/10 - 12/08/10)
- Diagnostics (06/17/09 – 07/16/10)
- PPE (08/10/10)

- Diagnostics (06/17/09 – 07/16/10)
- Office visits (08/19/10 - 12/08/10)
- Utilization review (11/30/10 – 12/15/10)

TDI

- Utilization review (11/30/10 – 12/15/10)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who with a coworker was tightening a bolt on the machine using a ratchet on xx/xx/xx. The ratchet broke as the patient and the coworker were pulling on it. This caused both men to fall backwards off the stairs they

were standing on. The patient fell in a seated position and struck his back against a metal wall.

In xx/xx, magnetic resonance imaging (MRI) of the lumbar spine revealed left subarticular 8 mm disc protrusion/extrusion at L4-L5 impinging on the origin of the left L5 nerve root and bilateral spondylolysis at L5-S1 without significant spondylolisthesis and a disc bulge without significant foraminal stenosis.

In May 2010, the patient was seen at Health Center for lumbosacral pain rated at 7/10 radiating into the left lower leg interfering with activities. Examination revealed weakness in the muscles of the legs and lumbar spine, tenderness in the lumbar erector spinae, positive Bechterew and decreased range of motion (ROM) in the lumbar spine. The evaluator diagnosed lumbar sprain/strain, intervertebral disc displacement and lumbosacral radiculitis. He recommended active modalities and pain medications. He opined the patient was getting left leg muscle atrophy and hence needed electromyography/nerve conduction velocity (EMG/NCV) of the lower extremities and disagreed with impairment rating (MMI).

MRI in July 2010 revealed evidence of apparent postoperative changes at the L4-L5 level with posterior annular evidence of granulation without focal protrusion. There was left foraminal narrowing at L4-L5. Mild disc disease and posterior element hypertrophy noted at the L5-S1 level with some bilateral foraminal narrowing.

M.D., a neurosurgeon, evaluated the patient for weakness in legs. The patient was utilizing Skelaxin and Celebrex. The patient was status post lumbar laminectomy at L4-L5 and L5-S1 performed on January 27, 2010. Examination revealed weakness in dorsiflexion of the left foot and inability to lift the big toe. He recommended postsurgical aquatic therapy and released the patient to light duty work.

In a physical performance evaluation (PPE) dated August 10, 2010, the evaluator noted the following treatment history: *Following the injury the patient was seen by the company doctor where he was x-rayed and returned to work with restriction. The patient continued with the company doctor for about five months during which time he underwent an MRI of the lumbar spine. MRI revealed a moderate board-based disc protrusion at L4-L5 and bilateral L5 spondylolysis without spondylolisthesis. The patient was referred to Dr. for consultation. However, the patient decided to seek a second opinion and in November 2008, presented to Health Centers where he received conservative treatment. In April 2009, EMG/NCV study revealed a left L5 motor radiculopathy and possible left S1 motor radiculopathy. In October 2009, Dr. performed a designated doctor exam and felt the patient was not yet at maximum medical improvement (MMI). On January 27, 2010, the patient underwent a partial hemilaminectomy at L4-L5 and L5-S1 on the left, left L5 and S1 nerve root decompression, foraminotomy and partial facetectomy at two levels. M.D., a designated doctor, assessed MMI as of April 24, 2010, and assigned 6% permanent impairment. The patient qualified at light to medium physical demand level (PDL) versus medium PDL required by his job and was recommended behavioral assessment and chronic pain management program (CPM).*

In October, the patient was seen at Health Center and was noted to be attending CPM. In November, the physician prescribed Biofreeze.

Dr. noted complaints of persistent weakness in the legs, although better strength than before and pressure and tightness in the buttocks. Dr. prescribed Elavil. On follow-up in November, the patient reported complaints of occasional pain and reported whenever he felt any type of pain he had problem with his erection. Dr. refilled Elavil, released patient to work with restrictions and recommended home therapeutic exercises.

Per Utilization review dated November 30, 2010, request for EMG/NCV of the lower extremities was denied with the following rationale: *“As per medical reports, the patient is complaining of low back pain with weakness on the left foot on dorsiflexion and inability to lift the big toe. There is restricted ROM of the lumbar spine. A comprehensive physical examination is needed in the medical report regarding the motor and sensory functions and deep tendon reflexes of the lower extremities, to include also serial assessments from the time of injury up to present to note for progression of neurologic deficits. The patient underwent partial hemilaminectomy at left L4-L5 and L5-S1, nerve root decompression at left L5 and S1, foraminotomy and partial facetectomy at two levels on January 27, 2010. MRI of the lumbar spine on July 16, 2010, showed postoperative changes at L4-L5 with no canal stenosis, left foraminal narrowing at this level, mild disc disease and posterior element hypertrophy at L5-S1 without canal stenosis but there is some bilateral foraminal narrowing. EMG/NCV on April 22, 2009, showed left L5 motor radiculopathy and possible left S1 motor radiculopathy. However, this was done preoperatively and the official report was not submitted for review. The patient was given pain medications and underwent physical therapy. Objective documentation of the patient’s response to optimal conservative measure are needed in the medical report with assessment in terms of VAS scale for pain control, reduction in medication use and performance of activities of daily living. Hence, the medical necessity of EMG/NCV of bilateral lower extremities is not established at this time.*

In December, the patient was seen at Health Center for pain in the lumbar spine radiating to the left leg. Review of system was positive for restricted motion, joint pain, back problems, mood changes, depression, excessive stress, and unsteady gait and numbness. Examination revealed an 8-cm old scar on the middle of the left lumbar paraspinal muscle with tenderness at the middle portion, decreased ROM of the lumbar spine to extension and side bending, positive SLR at 30 degrees, decreased bilateral patella reflexes to 2/4 and decreased lower leg pain sensation at L4, L5 and S1 nerve root distribution on the left side only. The evaluator assessed lumbar disc displacement and lumbosacral neuritis. He stated EMG could be used to detect abnormal electrical activity of muscle that could occur in many diseases and conditions including muscular dystrophy, inflammation of muscles, pinched nerves and peripheral nerve damage.

An appeal for EMG/NCV of bilateral lower extremities was denied on December 15, 2010, with the following rationale: *“The patient complained primarily of weakness in his left leg. Guidelines state that EMG may be recommended as an option to obtain unequivocal evidence of radiculopathy after one month of conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious and nerve conduction studies are not recommended as there is*

minimal justification for performing NCV studies when the patient is presumed to have symptoms on the basis of radiculopathy. The documentation submitted for review revealed the patient had physical signs of radiculopathy making electrodiagnostic studies clinically unnecessary. As such, the request for appeal of EMG/NCV bilateral lower extremities is non-certified.”

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

In summary, the claimant injured himself on xx/xx/xx, received multiple MRIs (06/18/08, 06/17/09 and 07/16/10) and electrodiagnostics on 04/22/09 that demonstrated lumbar spine disc disorders and radiculopathy respectively. The employee underwent surgery on 01/27/2010. The employee was certified at maximum medical improvement by a designated doctor on 04/24/10. It appears that he received 20 sessions of chronic pain management therapy post surgery. There was a request for more neurodiagnostics that was denied on 11/30/2010 and then an appeal that was also denied on 12/15/2010. I found no remarkable documentation from the provider that would support the requirement for more neurodiagnostics in this case. The ODG was quoted multiple times and I will state once again. ODG states that an EMG may be obtained to establish unequivocal evidence of radiculopathy which was done on 04/22/09 in this case. Moreover, EMG is not recommended where radiculopathy is already clinically obvious.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES ONLINE EDITION**