

SENT VIA EMAIL OR FAX ON  
Jun/27/2011

## True Resolutions Inc.

An Independent Review Organization  
500 E. 4th St., PMB 352  
Austin, TX 78701  
Phone: (214) 717-4260  
Fax: (214) 276-1904  
Email: rm@trueresolutionsinc.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jun/27/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

1 Electromyography Nerve Conduction Velocity (EMG/NCV) of the Bilateral Lower Extremities

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

M.D., Board Certified Physical Medicine Rehabilitation/Pain Management

**REVIEW OUTCOME:**

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

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

1. Utilization review determination letter 05/21/11 regarding non-certification reconsideration electromyography / nerve conduction velocity (EMG/NCV) of bilateral lower extremities between 05/02/11 and 07/01/11
2. Utilization review determination letter 05/05/11 regarding non-certification prospective request for electromyography / nerve conduction velocity (EMG/NCV) of bilateral lower extremities between 05/02/11 and 07/01/11
3. Office visit notes D.C. 06/02/11
4. Functional capacity evaluation 04/01/11
5. EMG/NCV study 03/08/10
6. MRI lumbar spine 11/23/09
7. Operative note 05/19/10 right L5-S1 hemilaminectomy / discectomy
8. MRI lumbar spine 04/01/11
9. Letter of referral and request for treatment authorization form
10. Peer review M.D. 01/24/11

## **PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate he was lifting heavy trash containers when he suddenly felt severe lumbar spine pain. MRI of lumbar spine performed 11/23/09 revealed a large right paracentral disc extrusion at L5-S1 with inferior migration disc occupying the right lateral recess impinging and contacting the right S1 nerve root; marked right neural foraminal stenosis. Electrodiagnostic testing performed on 03/08/10 reported acute severe L5 radiculopathy on the right. On 05/19/10 the patient underwent right L5-S1 hemilaminectomy and discectomy. A peer review performed on 01/24/11 concluded that based on review of exam findings by designated doctor and treating surgeon there were no additional diagnostics, injections, or surgeries reasonably required for further medical care. The injured employee was noted to have residual symptoms status post L5-S1 discectomy, with no objective evidence of ongoing radiculopathy. It was noted the injured employee was found to be at MMI by designated doctor as of 10/15/10 and released to light duty work.

A request for electromyography / nerve conduction velocity (EMG/NCV) of bilateral lower extremities was reviewed and determined not to meet established criteria for medical necessity per determination dated 05/05/11. It was noted per medical report dated 04/12/11 the injured employee complains of low back. Physical examination revealed tenderness at medial portion of lumbar spine, restricted range of motion, 4-/5 muscle strength, positive straight leg raise on right, and decreased sensation at L5-S1 nerve root distribution on right. Per the review, current physical examination findings and MRI imaging results were consistent with radiculopathy, so it was unclear why repeat diagnostic studies particularly NCV studies were necessary to confirm or rule out possible radiculopathy or nerve injury. It was further noted that there was a lack of information to explain how results of requested studies would be used to make treatment recommendations and decisions. The records submitted contain no clinical documentation of the requesting provider, and during peer to peer conversation with him he confirmed he never has seen the patient, he was referred to him only to perform requested studies.

A reconsideration / appeal request was reviewed on 05/25/11 and again determined the request to be non-certified as medically necessary. In acknowledgment of the previous non-certification due to lack of documentation of why repeat electrodiagnostic studies were necessary given the current physical examination findings and MR imaging results consistent with radiculopathy, there is now documentation the claimant presented with pain involving lumbar spine joint that radiates down right buttock and posterior aspect of right leg, right foot numbness and tingling sensation. Physical examination was noted to reveal crepitus, inflammation, tenderness at medial portion of lumbar spine. Range of motion was restricted. Strength testing of left iliopsoas muscle was graded at 4-, right iliopsoas 3-, left quadriceps 4-, right quadriceps 3-. Straight leg raise test of right leg was positive. Lower leg pain sensation was decreased at nerve root L5, S1 located right side only in nerve root distribution. MRI showed postoperative changes in posterior soft tissues at L5-S1 level, small 6 mm right posterolateral disc protrusion at L5-S1 with disc material abutting the descending right S1 nerve root and lateral recess, mild disc signal loss without disc height loss from L3-S1, mild bilateral neural foraminal narrowing at L4-5 and L5-S1 secondary to disc bulge and facet joint hypertrophic changes with disc material abutting the inferior aspect of the exiting nerve roots bilaterally at L5-S1. Treatment was noted to include medication, chiropractic treatment, and physical therapy. However, the review noted that current evidence based guidelines does not support electrodiagnostic studies if radiculopathy is already clinically obvious. Therefore, medical necessity of the request was not substantiated.

## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

Based on the clinical information provided, the proposed EMG/NCV of bilateral lower extremities is not indicated as medically necessary. The injured employee sustained a lifting injury to low back on xx/xx/xx. Imaging studies revealed a large right paracentral disc

extrusion occupying the right lateral recess and impinging the right S1 nerve root, with marked right neural foraminal stenosis. The patient underwent right L5-S1 hemilaminectomy and discectomy on 05/19/10. He continued to complain of low back pain radiating to lower extremities. Repeat MRI performed 04/01/11 revealed postoperative changes at L5-S1; small 6 mm right posterolateral disc protrusion at L5-S1 with disc material abutting the descending right S1 nerve root in lateral recess; mild disc signal loss without disc height loss L3-S1; mild bilateral neural foraminal narrowing at L4-5 and L5-S1 secondary to disc bulge and facet joint hypertrophic changes with disc material abutting the inferior aspect of the exiting nerve roots bilaterally at L5-S1. On examination the injured employee was noted to have restricted range of motion in all planes of lumbar spine. There was weakness noted in the right greater than left iliopsoas muscle and right greater than left quadriceps. Straight leg raise was positive on right. Sensation was decreased in right lower extremity in L5-S1 dermatomal distribution. Per ODG guidelines, EMG may be useful to obtain unequivocal evidence of radiculopathy after 1 month of conservative treatment, but EMG's are not medically necessary if radiculopathy is already clinically obvious. In this case radiculopathy is clinically obvious with motor and sensory changes in right lower extremity as well as positive straight leg raise on right. Consequently EMG/NCV is not necessary to confirm or rule out possible radiculopathy or nerve injury as radiculopathy is already clinically obvious.

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

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)