



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

## Notice of Independent Review Decision-WC

**DATE OF REVIEW: 7-7-11**

**IRO CASE #:**

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

EMG/NCV Bilateral lower extremities 95903, 95904, 95861, 95934, A4215, A4556, A4558

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

Chiropractor

### **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)

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.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- 7-22-09 DC., office visit.
- 8-4-09 J MD., Designated Doctor Evaluation.
- 8-5-09 DC., office visit.
- Chiropractic Therapy at Spine and Rehabilitation Centers on 8-6-09, 8-7-09, 8-12-09, 8-14-09, 8-17-09, 8-19-09, 8-21-09, 8-24-09, 8-26-09, 8-28-09, 9-4-09, 9-9-09.
- 9-2-09 DC., office visit.
- 9-22-09 DC., office visit.
- 11-4-09 DC., office visit.
- 12-4-09 Functional Capacity Evaluation.
- 12-4-09 MRI of the lumbar spine performed by MD.
- 12-4-09 X-ray of the lumbar spine performed by MD.
- 12-15-09 MD., Impairment Rating.
- 12-17-09 EMG-NCS performed by MD.
- 1-4-10 MD., office visit.
- 1-29-10 MD., office visit.
- 2-3-10 DC., office visit.
- 4-5-10 MD., office visit.
- 4-14-10 DC., office visit.
- 4-26-10 MD., Peer Review.
- 4-29-10 DC., office visit.
- 5-14-10 MD., Designated Doctor Evaluation.
- 5-20-10 DC., office visit.
- 6-10-10 DC., office visit.

- 6-18-10 MD., office visit.
- 7-22-10 MD., Peer Review.
- 8-19-10 DC., office visit.
- 9-16-10 MD., Post Designated Doctor's Required Examination.
- 9-23-10 DC., office visit.
- 11-2-10 DC., office visit.
- 1-7-11 MD., office visit.
- 1-13-11 DC., office visit.
- 2-7-11 MD., office visit.
- 2-21-11 DC., office visit.
- 2-25-11 MD., office visit.
- 3-14-11 MD., office visit.
- 3-25-11 MD., office visit.
- 4-7-11 DC., office visit.
- 5-5-11 DC., office visit.
- 5-6-11 DC., Medical Review.
- 5-9-11 MD., office visit.
- 6-2-11 DC., Medical Review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

DC., the claimant reported reports that on the job he loads and unloads approximately 10,000-12,000 pounds per day on average. He is constantly pulling and pushing over 100 pounds himself, especially going down stairs. Muscle relaxant helps the pain. Lifting and daily activities make the pain worse. The quality of the pain is sharp with some radiation down into the lower extremities, especially down the right hip. Impression: Lumbar herniated nucleus pulposus and lumbar radiculitis. Plan: Request physical therapy, add some myofascial release to reduce scar tissue formation and therapeutic procedures 4 units to increase range of motion, strength, and function-request 3x a week for the next 4 weeks, 12 visits and follow up. Remained on light duty, issued an EMS. DWC-73: The claimant was returned to work from 7-22-09 through 8-22-09 with restrictions.

8-4-09 MD., performed a Designated Doctor Evaluation. The evaluator felt the claimant suffered a low back myofascial strain in the performance of his work duty.

8-5-09 DC., the claimant reported for follow up. The claimant had brought his MRI for the evaluator to look at it. It was his opinion that disc pathology at L5-S1 disc showed

that had about 4-5mm protrusion, which on the axial view did not appear to be impinging on the nerve roots. It did appear to be pressing on the thecal sac centrally though and the signal was decreased inside, it looked like there was some disc dehydration as well and loss of disc height. Plan: The claimant got physical therapy approved and follows up in 6 visits.

Chiropractic Therapy from 8-6-09 through 9-9-09 (12 sessions).

9-2-09 DC., the claimant returned for follow up. The claimant had completed his therapy and had made some functional gains. The claimant progressed with his strength and range of motion improvements. He had tolerated the treatment well. The claimant still had some stiffness with certain movements in the low back. Overall the core stabilization worked well. On exam, the lumbar range of motion was over 60 degrees. Lumbar extension was to 21 degrees, which was an improvement from the last time. Left and right lateral flexion was WNL. The lumbar extension was still decreased. His strength was up in the low back. Trunk flexion was to 37.5 pounds, trunk extension to 35.8 pounds, trunk rotation to 25.6 pound on the left and 27.9 pounds on the right. Those were improvements of 7 pounds and 8 pounds respectively since the last time. Lower extremity muscle strength had improved as well at all stations. Deep tendon reflexes were normal bilaterally. Dermatome testing still revealed hypoesthesia in the L4, L5, and S1 levels on the right. Plan: The evaluator gave him home exercise program and follow up.

9-22-09 DC., the claimant returned for follow up. The claimant did go to a BRC hearing. They were only willing to give him a strain-sprain. He was not willing to accept that considering the amount of damage that was done at on the job injury and the amount of issues he had been having; therefore they were going to go on to a hearing. Plan: Follow up after the hearing took place and home exercises.

11-4-09 DC., the claimant returned for follow up. The claimant was a 4-10 overall VAS pain scale. The claimant still had low back pain, mainly radiating down to the right leg. Physical Examination: Essentially unchanged. Impression-Plan: The evaluator did not have the report back from BRC hearing.

12-4-09 Functional Capacity Evaluation showed the claimant was functioning at a Medium PDL.

12-4-09 MRI of the lumbar spine performed by MD., showed disc desiccation to the L5-S1 disc and modic type II signal abnormality, anterosuperior endplate of L4. L1-2, no extradural defect. No spinal canal stenosis. No neural foraminal narrowing. L2-3, no extradural defect. No spinal canal stenosis. No neural foraminal narrowing. L3-4, no extradural defect. No spinal canal stenosis. There was mild neural foraminal narrowing bilaterally and a very mild hypertrophic change of the articular facets. No extrinsic compression against the exiting nerve root sleeves. L4-5, 2-3mm annular symmetric bulge of the disc, moderately advanced neural foraminal narrowing bilaterally, mild to moderate hypertrophic change of the articular facets, possible extrinsic compression

against the existing L5 nerve root sleeves bilaterally. L5-S2, 3mm annular symmetric bulge of the disc, bilateral advanced neural foraminal narrowing, moderate to advanced hypertrophic change of the articular facets, possible extrinsic compression against the existing S1 right nerve root sleeve.

12-4-09 X-ray of the lumbar spine performed by MD., showed mild straightening of the normal lordotic curve, could indicate muscle spasm. The study was otherwise unremarkable.

12-15-09 MD., performed a Designated Doctor Evaluation. He certified the claimant had reached MMI on 12-15-09 and awarded the claimant 5% whole person impairment based on DRE Category III.

12-17-09 EMG-NCS performed by MD., showed no electro diagnostic evidence of lower extremity neuropathy and no electro diagnostic evidence of lumbar radiculopathy.

1-4-10 MD., the evaluator noted that the claimant had discogenic lumbar pain and multilevel disc bulges as a result of the injury. The evaluator gave the claimant options: to live with the pain, continued physical therapy or undergoing a series of lumbar ESI. The claimant wished to go under with series of lumbar ESI. The evaluator discussed it might have been a temporarily alleviate to his pain or no improvement; and the claimant wished to proceed. The evaluator interpretation of MRI of lumbar noted there was a disc bulge at L4-5 and L5-S1 measuring 3mm. There was neural foraminal stenosis at L3-4 through L5-S1. There was facet hypertrophy at L3-4 through L5-S1. The remainder of the lumbar spine MRI was unremarkable.

1-29-10 MD., the claimant complains of pain and stiffness in both sides of the lower back. The claimant has undergone a course of physical therapy. On exam, the claimant has normal motor strength, sensation and reflexes of the upper and lower extremities. The claimant has restricted range of motion. The evaluator gave him the same options as prior and the claimant wished to proceed with epidural steroid injection.

2-3-10 DC., the claimant returned for follow up visit. The claimant was reported transient pain down to both legs, down to the calves and sometimes in the right leg all the way down to the foot itself. Impression-Plan: Epidural steroid injections were to be the next step, an EMG of the lower extremities, get an MMI and follow up.

4-5-10 MD., the claimant states that his low back pain is a level 7 of 10. He has been denied twice for a lumbar ESI by his insurance company. The evaluator discussed his symptoms, diagnosis and the expected future course of his recovery. He understood the discussion and all of his questions were answered. The evaluator discussed activities that he should avoid to prevent further aggravation of his symptoms. He was shown exercises that he may perform to decrease his pain and improve his function. The evaluator recommends that the claimant continue his course of physical therapy. He will need to file an IRO if he wishes to undergo the lumbar ESI. The claimant was asked to return on a prn basis for a follow-up visit.

Follow-up visit with Dr. on 4-14-10 notes the evaluator is going to follow-up with the claimant on the ombudsman has a chance to work on the letter of clarification that was sent out trying to get his strain-sprain accepted as an HNP so he can proceed forward with his treatment.

4-26-10 MD., performed a Peer Review. It was his opinion that the medical records reflect the claimant strained his lower back while bending over to lift boxes. The claimant was treated with medications and chiropractic therapy. He has undergone MRI of the lumbar spine which showed pre-existing neural foraminal narrowing and hypertrophic changes on multiple levels. Electro diagnostic testing of the lower extremities was normal. Documentation notes the claimant had a BRC in which a lumbar strain was ruled as compensable. On 12-15-09, the claimant was evaluated by a Designated Doctor and was placed at MMI with a 5% impairment rating. There has been a recommendation for lumbar epidural steroid injection. However, physical exam findings showed no evidence of neurological deficits in addition to the normal electro diagnostic testing. He enclosed ODG data regarding indications for epidural steroid injection. As it relates to the compensable injury, a lumbar strain, there is no indication for further active care since the claimant has been given an impairment rating. The claimant sustained a lumbar strain, which should have healed by now. There is no indication for further diagnostic testing, chiropractic care or the use of prescription medications. As it relates to the requested epidural steroid injection, ODG does not support an epidural steroid injection in a claimant with a normal neurological examination. Therefore, this form of treatment is not indicated. Further care should be based on maintenance care with follow up visits 2-3 times a year and the use of an over the counter anti-inflammatory medication.

4-29-10 DC., the evaluator wanted to communicate what has been going on with the claimant since the last time you saw him. He has recently been to be a BRC hearing and his injuries have been deemed work related after winning his case and are direct the result of the accident on the job. At that time the evaluator were finally able to order a quality MRI of his lumbar spine. The MRI shows disc desiccation at L5-S1 with a 3-mm annular bulge. There is also advanced neuroforaminal narrowing and hypertrophic changes of the articular facets with compression on the right S1 nerve roots. At the L3 and L4 levels he is showing some hypertrophic changes of the articular facets as well as some compression of the 15 nerve roots bilaterally. This MRI was of higher quality, 1.5 Testa magnet and showed more detail than his previous MRI back in 6-09. It is the evaluator's beliefs and the belief of Dr. orthopedic spine specialist that the evaluator sent him out to the claimant is suffering from low back disc impingement as well as facet syndrome. This claimant had an FCE and also that showed he is in medium PDL and his job requires very heavy. The claimant is required to pickup 150-200 pounds quite frequently, dead lifting on and off of pallets that he carries his supplies around on. The evaluator's treatment goal is to get him out of pain that he has in his low back with the facet injections and epidural steroid injections and then the evaluator might put him in a work conditioning program for a few weeks or a month to see if the evaluator can get his PDL back up to return to full duty as soon as possible.

The evaluator would have accomplished this if his epidural steroid injections had not been denied. They were denied because the case has only been accepting a strain-sprain as of yet instead of accepting the facet and disc pathology as part of his injuries. He was functioning at 100% level prior to injuring himself on the above-mentioned date. He had not had any radiculopathy or back issues prior to that. Even his primary care physician's records for the year-and-a-half prior to the injuries show that he was in perfect health and had no some limitations nor do his evaluations on his job show any limitations physically either. Hopefully that will bear weight to the extent of these direct injuries for low back radiculopathy and protrusions.

5-14-10 MD., performed a Designated Doctor Evaluation. The evaluator was asked to determine the extent of the compensable injury. It was his opinion that the extent of injury included L5 and S1 nerve root compromise by neuroforaminal stenosis and L4-L5-S1 facet joint synovitis. The evaluator recommended epidural steroid injections, facet injections and NSAID's.

5-20-10 DC., the claimant returns to the office today. He is here from seeing the designated doctor. The designated doctor determined the extent of injury to be L5 and S1 nerve root compromise with neuroforaminal stenosis due to the disc pathology as a result of the accident on the job and L4, L5, and S1 facet joint synovitis was part of it. He is recommending epidural steroid injections, facet joint injections, steroids, and NSAIDs for medication. Impression-Plan: The evaluator is going to send the above back to Dr. and have him commence with that treatment to get the claimant some relief here finally. The evaluator will follow up with him after he sees Dr.. The claimant understands, consents to treatment, and has no further questions.

6-10-10 DC., the claimant returns to the office today. He is curious about his Naprosyn. He has not taken any nonsteroidal anti-inflammatory since the last prescription. Impression-Plan: The evaluator did tell him the Naprosyn he was taking; he can get it over-the-counter in the form of Aleve for anti-inflammation, so he is going to try to do that. The evaluator is still waiting on some paperwork for the claimant. Once the evaluator gets that he will be able to proceed forward with his case.

6-18-10, MD., the claimant returned for a follow-up visit. The claimant is being followed for a lumbar strain-sprain as a direct result of a work related injury on xx/xx/xx. He is here for a follow-up evaluation. He is undergoing a course of physical therapy. He is improved with the therapy but is still symptomatic. He states that his low back pain is a level 6 of 10. He has been denied twice for a lumbar ESI by his insurance company. He is filing a BRC to change his accepted diagnosis. He underwent a DDE who recommended that he undergo a lumbar ESI. Exam: Motor strength, sensation and reflexes are normal in both upper and lower extremities. Upper extremity-spine: There is moderate restriction in flexion, extension and rotation of the lumbar spine. He has tenderness to palpation in the lumbar spine. Straight leg raising is negative bilaterally. Neurologic testing is normal in the upper and lower extremities. Assessment-Plan: The evaluator discussed activities that he should avoid to prevent further aggravation of his symptoms. He was shown exercises that he may perform to decrease his pain and

improve his function. The evaluator recommends that the claimant continue his course of physical therapy. The evaluator agrees with the DDE that this claimant is a candidate for a lumbar ESI. He will need to complete the BRC process before approval can be given to undergo the lumbar ESI. The claimant was asked to return on a prn basis for a follow-up visit.

7-22-10 MD., performed a Peer Review. It was his opinion that the claimant strained his lower back while bending over to lift boxes. The claimant was treated with medications and chiropractic therapy. He has undergone MRI of the lumbar spine which showed pre-existing neural foraminal narrowing and hypertrophic changes on multiple levels. Electro diagnostic testing of the lower extremities was normal. Documentation notes the claimant had a BRC in which a lumbar strain was ruled as compensable. On 12-15-09, the claimant was evaluated by a Designated Doctor and was placed at MMI with a 5% impairment rating. There was a recommendation for lumbar epidural steroid injection. On 5-14-10 MD., performed a Designated Doctor Evaluation to determine the extent of the compensable injury. It was his opinion that the extent of injury included L5 and S1 nerve root compromise by neuroforaminal stenosis and L4-L5-S1 facet joint synovitis. The evaluator recommended epidural steroid injections, facet injections and NSAID's. As noted in my prior review, this claimant has a normal neurologic physical exam. The Designated Doctor Evaluation on 5-14-10 did not show any evidence of radiculopathy. His reflexes were 2 at bilateral patella and 3 at bilateral Achilles. He noted the claimant was able to perform heel walk and toe walk without difficulty. The only positive documentation was the claimant's complaints of lower back pain and pins and needles sensation in the lower back and bilateral legs, but no objective documentation of radiculopathy. Therefore, he respectfully disagree with Dr. recommendation for epidural steroid injection, as this does not follow ODG criteria. Per ODG, the first criteria required for epidural steroid injection "Radiculopathy must be documented. Objective findings on examination need to be present. "This claimant does not meet ODG criteria for epidural steroid injections, therefore, He did not agree with this recommendation. Dr. also noted the recommendation for facet injections. He also respectfully disagrees with this recommendation. In his physical exam, there was no evidence of facet mediated pain. The request for facet injections and epidural steroid injection would be in direct contraindication of each other. ODG states that facet injections are under study and one of the criteria's for performing a facet injection is no evidence of radicular pain. The indication for epidural steroid injection is for radicular pain. Therefore, the request for both injections contraindicates each other. He enclosed ODG data regarding facet blocks-injections. As noted in his prior Peer Review, further care should be based on maintenance care with follow up visits 2-3 times a year and the use of an over the counter anti-inflammatory medication.

8-19-10 DC., the claimant returns to the office today. He reports that his BRC hearing with his ombudsman is going to be Monday, 9-8-10. They will be determining the extent of injury. Right now they have only gotten him accepted his lumbar strain-sprain. Impression-Plan: The evaluator is trying to get the disc pathology accepted so that he can move forward on the epidural steroid injections and follow up with Dr. regarding his

treatment plan. The evaluator will follow up with him once the BRC hearing is completed.

9-16-10 MD., he performed a Post Designated Doctor's Required Examination. It was his opinion based on the records supplied and his physical examination, in his opinion, the only thing the claimant could have had was a lumbosacral strain. If one looks at all the objective testing including the MRI and repeat MRI it all shows disease of life findings with bony changes and hypertrophic changes but no evidence of herniated disc or nerve root compression. As a matter of fact, the EMG-nerve conduction study is totally normal. Physical examination today shows straight leg raise negative sitting and supine, no sensory deficits, no strength deficits, no atrophy. Reflexes are 2+ and equal so there are just no findings whatsoever of radiculopathy. Looking at these films the evaluator think the only thing you can document would be a lumbosacral strain superimposed on preexisting significant degenerative changes.

9-23-10 DC., the claimant returns to the office today. He is working with an ombudsman to try to get his disc herniation added to his case. They are trying to stick with the fact he only has a sprain-strain when indeed he does have lumbar disc issues that are showing up on MRI and physical exam findings both with the evaluator's office and with Dr. office, his orthopedic surgeon. Physical Examination: Essentially unchanged. Impression-Plan: The evaluator is going to draft the letter to explain that and the evaluator will provide it to them so they can go to a BRC hearing. The claimant understands, consents to treatment, and has no further questions.

Follow-up visit with Dr. on 11-2-10 notes the evaluator will refer him to Dr. to help him with his medications. The evaluator is still waiting to hear from his ombudsman.

1-7-11 MD., the claimant returned for a follow-up visit. The claimant complains of pain and stiffness in both sides of the lower back. His pain level at 7 of 10. The claimant has a lumbar strain-sprain as a direct result of a work related injury on xx/xx/xx. The evaluator had a long discussion with the claimant concerning his low back pain. The evaluator explained to him the reasons for his continued pain, the natural history of his low back pain and his treatment options. His options include living with the pain, continuing physical therapy or undergoing a series of lumbar ESI. He understood the discussion and all of his questions were answered. He wishes to undergo a lumbar ESI since he has not improved with extensive conservative treatment. The evaluator discussed the fact that the injection may alleviate all of his pain, it may temporarily alleviate his pain or rarely offer any improvement in his pain. He understands the risk benefits of the procedure and wishes to proceed. The evaluator explained to him that he would be able to perform the procedure and that the evaluator's office will obtain the precertification.

Follow-up visit with Dr. on 1-13-11 notes the claimant did get to see Dr. and he recommended ESI and the claimant wants to proceed forward with that. The evaluator will follow-up after he has a chance to have that approved.

Follow-up visit with Dr. on 2-7-11 notes the evaluator recommended physical therapy. The claimant will need to file an IRO since he has been denied twice for a lumbar ESI.

Follow-up visit with Dr. on 2-21-11 notes the evaluator is going to request therapy and once approved he will be able to follow-up with him to commence with treatment.

2-25-11, MD., the claimant is seen in consultation at the request of Dr.. This is a gentleman with chief complaint of low back pain with radiation to the buttocks rated VAS score up to 8-10. The claimant describes the pain as sharp, shooting, aching with episodic muscle spasms in the lower extremities depending on activity. The claimant was involved in a work related injury secondary to a lifting type mechanism. Subsequent to the injury, he has been having issues with worker's compensation for almost three years. No injections have been approved. No surgery has been performed. The claimant has not returned to work force. Physical Examination: Focus examination of the lumbar spine reveals bilateral lumbar paraspinal muscle tenderness noted of moderate degree diffusely localized throughout. Range of motion is diminished with extension, lateral bending and rotational maneuvers. Straight leg raise is negative bilaterally in the sitting and supine position to 90 degrees. Lumbar facet joints are tender to palpation bilaterally at L3-L4 to L5-S1 levels. Motor strength in the lower extremities is equal and symmetrical bilaterally, but weak. Reflexes in the lower extremities are 1-4 bilaterally. Impression: Lumbago, completed conservative treatment as related to the worker's compensation injury. Plan: In terms of medications, the evaluator has provided Naprelan, Amrix. Home exercise protocol reinforced. The claimant is to follow up with this clinic in one month for evaluation of medication efficacy.

Follow-up visit with Dr. on 3-14-11 notes the evaluator recommended ESI. He understands the risk benefits of the procedure and wishes to proceed. The evaluator explained to him that he would be able to perform the procedure and that the evaluator's office will obtain the precertification.

3-25-11 MD., the claimant is seen in follow-up today. He has a working diagnosis of lumbago. The claimant notes his low back pain rated at a VAS score of 8-10. He is very distraught today. He states that the insurance company not providing any type or accepting treatment whatsoever to include medication management. He has not returned back to workforce. Physical Examination: Focus examination of the lumbosacral spine is essentially unchanged from the visit of 2-25-11. Impression: Lumbago, insurance company is not providing any type of medical-pharmaceutical treatment. Plan: The claimant is to follow-up with this clinic on an as needed basis if and when his case is accepted and appropriate treatment options can be provided.

Follow-up visit with Dr. on 4-7-11 notes the evaluator is waiting on his IRO. He did some IRO for his EMG. The evaluator is requesting for the EMG again today.

Follow-up visit with Dr. on 5-5-11 notes the evaluators will follow-up with the claimant as soon as he get the EMG approved.

5-6-11 DC., performed a Medical Review. There is no evidence to indicate the need for this electrical diagnostic study (EMG/NCV) requested to bilateral lower extremities. The

reports from Dr. 3/14/11 noted normal neurological evaluation. There does not appear to be any progressive neurological deficit or rationale for repeat EMG/NCV. Furthermore, there is no indication as to how this study would change treatment recommendations. It is noted that Dr. is recommending epidural. It is not clear how this study will be helpful in guiding/changing treatment recommendations. Non-certify request for EMG/NCV bilateral lower extremities as not adequately supported by documentation to be considered medically necessary, appropriate, or consistent with the guidelines in this case. Determination: Non-certified

5-9-11 MD., the claimant returned for a follow-up visit. This claimant has a lumbar strain-sprain as a direct result of a work related injury on xx/xx/xx. The evaluator had a long discussion with the claimant concerning his pain. The evaluator explained to him the reasons for his continued pain, the natural history of his pain and his treatment options. He understood the discussion and all of his questions were answered. He wishes to undergo a lumbar ESI since he has not improved with extensive conservative treatment. The evaluator discussed the fact that the injection may alleviate all of his pain, it may temporarily alleviate his pain, or rarely offer any improvement in his pain. He understands the risk-benefits of the injection and wishes to proceed. The evaluator explained to him that he would be able to perform the injection and that the evaluator's office will obtain the precertification. Unfortunately he has been denied this medically necessary treatment by Dr. who performed a peer review. He cited the ODG. The evaluator had the opportunity to care for many patients for whom Dr. has performed lumbar ESI. These claimants did not meet the criteria set forth by the ODG. In fact, if one strictly went by the ODG, there would be no patient who ever satisfied the eleven or so criteria. If this claimant is again denied an ESI, he will file an IRO.

6-2-11 DC., performed a Medical Review. Dr. was not able to state why this testing was required for treatment. He did not know whether previous EMG testing was performed. This patient is currently x years from the date of injury and is now chronic. He has been assigned an impairment rating of 5 percent.

Determination: Non-certify EMG/NCV bilateral lower extremities 95903 95904 95861 95934 A4215 A4556 A4558. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request for Medical necessity for Appeal EMG/NCV bilateral lower extremities 95903 9590A 95861 95934 A4215 A4556 A4558 is not certified.

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

THIS REQUEST IS FOR ELECTRODIAGNOSTIC STUDIES FOR THE LOWER EXTREMITIES IN A CLAIMANT WITH A NEARLY X YEAR HISTORY OF LOWER BACK PAIN. A PRIOR EMG/NCS STUDY WAS NEGATIVE FOR EVIDENCE OF RADICULOPATHY AND NO RECENT EXAMINATION DEMONSTRATES FINDINGS CONSISTENT WITH LUMBAR RADICULOPATHY. THE RATIONALE FOR

REPEATING THIS TESTING IN A CLAIMANT WITHOUT PROGRESSIVE NEUROLOGICAL COMPROMISE IS UNCLEAR AND NOT SUPPORTED BY EVIDENCE-BASED MEDICINE. NO EXTENUATING CIRCUMSTANCES ARE PRESENTED TO ESTABLISH A CLINICAL NEED IN THIS CASE. THE MEDICAL NECESSITY OF EMG/NCS STUDIES FOR THE BILATERAL LOWER EXTREMITIES (95903, 95904, 95861, 95934, A4215, A4556, A4558) IS NOT ESTABLISHED BY GUIDELINES OR CLINICAL RATIONALE.

**ODG-TWC, last update 6-29-11 Occupational Disorders of the Low Back –**

**EMG/NCS:** 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.

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

- ACOEM- AMERICAN 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)**