

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 2/27/2011
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral lower extremity EMG/NCV

QUALIFICATIONS OF THE REVIEWER:

Chiropractor
DC

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)

Bilateral lower extremity EMG/NCV Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Notice to air analyses by MD, dated 2/7/2011
2. IRO request form dated 2/3/2011
3. Request form dated 12/20/2010
4. Letter by RN, dated 12/17/2010
5. Letter by LVN, dated 11/18/2010
6. Official Disability Guidelines (ODG)

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a female injured employee who was involved in a work injury on xx/xx/xx. The injury was described as a slip and fall resulting in injuries to her right knee and lower back. On 7/14/2010 the claimant was evaluated by Dr. DC, at the request of Dr., M.D., for repeat electrodiagnostic testing of the lower extremities. The report of this evaluation indicated that a 3/25/2010 electrodiagnostic evaluation proved to be normal. An MRI of the lumbar spine dated 3/18/2010 revealed degenerative changes including disc bulging at L4/5 and L5/S1. An MRI of the right knee dated 3/18/2010 revealed a lateral meniscus tear. A recommendation for a repeat EMG/NCV testing of the bilateral lower extremities was submitted. The EMG test was completed and reportedly revealed evidence consistent with active denervation/reinnervation process involving the left L5 and bilateral S1 nerve roots. The recommendation was for a repeat nerve conduction study. On 11/12/2010 a request for lower extremity NCV testing was submitted. On 11/17/2010 a peer review was performed regarding a request for bilateral lower extremity EMG/NCV testing. This was denied by peer review. The rationale was that "there is no evidence of progressive neurologic dysfunction. There has

been no surgery or significant events since the last electrodiagnostic study on 7/14/2010." An appeal letter was submitted that indicated that the request was for nerve conduction testing and not an EMG. On 12/17/2010 an appeal was completed that resulted in noncertification of bilateral lower extremity EMG/NCV testing. The request for a nerve conduction study was denied following peer to peer contact with Dr.. The peer review indicated that Dr. advised the peer review physician "that he did not have a current prescription from Dr. and that the request is based on a prescription dated July 2010." The request for NCV testing was denied. On 12/20/2010 a request for an IRO for bilateral lower extremity EMG/NCV testing was submitted. A MDR/IRO supplement report was submitted following the appeal letter.

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

The injured employee was injured on xx/xx/xx. On 3/25/2010 the injured employee underwent EMG/NCV testing of the lower extremities that proved to be normal. The submitted documentation revealed no evidence of a deterioration of the claimant's condition. On 6/7/2010 an examination was performed by Dr. M.D. At that time the injured employee complained of numbness and tingling in the lumbar region and bilateral lower extremities. It was noted that the injured employee underwent an epidural steroid injection provided "relief of some of her symptoms." It was further noted that "patient states pain to lumbar (decreased) a little post-injection only some tingling/numbness." The recommendation was for 4 sessions of therapy. On 7/2/2010 Dr. submitted a prescription for EMG/NCV of the bilateral lower extremities. There was no rationale for performing these tests. On 7/14/2010 the claimant was evaluated by Dr.. At that time the injured employee complained of moderate to severe low back pain that is centralized "with intermittent extension of symptoms into the buttocks/lower extremities." Positional changes and strenuous activities are provocative. However, the examination revealed no evidence of positive root tension signs. The examination did not support the medical necessity for EMG or NCV testing. The EMG/NCV testing from 3/25/2010 was normal. There was no evidence of deterioration of the injured employee's condition. Moreover, there was no evidence as to the treatment rendered this injured employee prior to performing these tests. ODG guidelines, web-based version, low back chapter indicates that EMG testing "may be useful to obtain unequivocal evidence of radiculopathy, after 1 month conservative therapy." The submitted documentation does not indicate whether or not the injured employee received any conservative treatment. The injured employee did receive an epidural injection to the lower back and reportedly provided overall improvement. ODG guidelines further indicate "EMGs are not necessary if radiculopathy is already clinically obvious." Again, there was no rationale for performing the EMG testing on 7/14/2010. There was also no rationale as to why Dr. did not perform the NCV testing at the same time as the EMG testing if it was as clinically necessary as he opined his request. The submitted documentation does not indicate whether or not the injured employee received any therapy in the intervening time period. Therefore, consistent with ODG guidelines, the medical necessity for the requested NCV testing was not established. The recommendation is to uphold the previous denial.

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)