MATUTECH, INC.
PO BOX 310069
NEW BRAUNFELS, TX 78131
PHONE: 800-929-9078
FAX: 800-570-9544

Notice of Independent Review Decision

DATE OF REVIEW: March 9, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
EMG/NCV lumbar spine and bilateral lower extremities

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Fellow American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME

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

X Upheld (Agree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:
This is a male who on xx/xx/xxxx was lifting a 500-lb rack with a coworker and the coworker let go of his side causing strain to the patient's lower back and left elbow.

On August 11, 2010, M.D., evaluated the patient for low back pain radiating to the legs, neck pain radiating to the arms and pain in the thoracic spine and in the left elbow. Examination showed decreased range of motion (ROM) of the cervical and lumbar spine and left elbow and tenderness in the cervical and lumbar spine. Dr. ordered x-rays, prescribed ibuprofen and Flexeril and treated the patient with nine sessions of physical therapy (PT). For complaints of nosebleed, he referred the patient for ENT consult.

In September, magnetic resonance imaging (MRI) of the lumbar spine showed: Left paracentral and left lateral 3-mm protrusion at L3-L4 creating effacement of the thecal sac with left-sided foraminal and L4 nerve root encroachment. Broad-based annular bulge at L4-L5 without focal disc herniations or stenosis. Straightening of the normal lumbar lordosis suggesting muscle spams.

MRI of the left elbow showed mild medial epicondylitis and mild joint effusion.

In a designated doctor evaluation (DDE), M.D., assessed clinical maximum medical improvement (MMI) as of November 11, 2010, and assigned 5% whole person impairment (WPI) rating. Regarding the extent of injury, he opined the patient sustained left elbow strain, left paracentral and lateral 3-mm protrusion at L3-L4, left foraminal and L4 nerve root encroachment and broad-based annular bulge at L4-L5.

Subsequently, Dr. noted the patient continued to have severe low back pain and pain to the bilateral ribs requiring him to go to hospital. Dr. obtained a functional capacity evaluation (FCE). In an FCE the patient demonstrated the ability to safely and dependably perform at a light physical demand level (PDL), which failed to meet the minimum job requirement. Dr. diagnosed left medial epicondylitis, lumbar intervertebral disc without myelopathy at L3-L4 and L4-L5 and muscle spasm. He recommended an orthopedic evaluation and refilled ibuprofen and Flexeril.

On January 4, 2011, M.D., noted tenderness along the band-like distribution, decreased lumbar ROM due to pain, muscle spasm, positive straight leg test (SLR) bilaterally and decreased sensation in the posterolateral thighs to the posterolateral calves. Dr. diagnosed lumbar strain with nerve root irritation and disc herniation and recommended electromyography/nerve conduction velocity (EMG/NCV) to further evaluate radiating symptoms into the legs and epidural steroid injections if the EMG test was positive. He recommended continuing anti-inflammatory medication on a regular basis.

On January 11, 2011, Dr. noted complaints of muscle weakness, unstable gait, paresthesias and cramping. The patient also complained of pain to the thoracic spine. He was willing to undergo injections. Examination showed radicular pain to the left lower extremity, 4/5 bilateral lower extremity strength, restricted lumbar ROM, muscle spasms in the thoracic spine and lumbar spine and positive Bechterew's, cervical compression and Lasegue's bilaterally and Bragard's and Kemp's on the left. Dr. referred the patient to a pain management physician for ESI x3 and recommended electrodiagnostic evaluation.

On January 26, 2011, per utilization review the request for EMG/NCV of the bilateral lower extremities was denied with the following rationale: "*The patient*

sustained his injury on xx/xx/xxxx, and has been reported to have pain in the lumbar spine with pain and paresthesias extending to the posterior calves. Physical examination dated January 4, 2011, showed band-like tenderness in the lower lumbar spine on palpation. Lumbar ROM is limited due to pain. Straight leg raise test was positive at 75 degrees bilaterally. Motor and reflex evaluations are normal. There is however, a decreased sensation in the posterolateral thighs to the posterolateral calves. Gait is normal. The clinical records submitted were reviewed upon the request for EMG/NCV of the bilateral lower extremities. However, the MRI study done showing suggestive findings of a radiculopathy at L3-L4 is not provided for review, which may already be sufficient to document the patient's pathology to indicate the contemplated epidural spinal injections. There is also none in the records that documents evidence of recent exhaustion of prior conservative care from participation in evidence-based physical treatments and

optimized medication management to consider further evaluation with this study. At this point in time, the medical necessity of this request is not fully established. Based on the clinical information submitted for this review and using the evidence based, peer reviewed guidelines referenced above, this request for EMG/NCV of the bilateral lower extremities is non-certified."

On February 7, 2011, Dr. noted complaints of low back pain rating an 8/10 and radicular pain into the thoracic and cervical spine, referred pain to the left rib cage from the low back and muscle tension in the bilateral trapezius muscles. There was improvement in the left elbow pain. The patient also had numbness and tingling in the ankles and intermittent numbness in the right hand and muscle spasm in the left upper extremity. There was 2+ muscle spams in the entire spine, restricted lumbar and cervical ROM and positive cervical compression, cervical distraction and shoulder depression; Lasegue's, Bragard's, and Milgram's tests bilaterally. Dr. added diagnosis of cervicalgia and changed ibuprofen to Naprosyn as ibuprofen caused stomach irritation. He appealed for EMG study.

On February 8, 2011, an appeal/reconsideration for EMG/NCV study of the bilateral lower extremities was denied with the following rationale: "*In the recent medical report dated January 11, 2011, the patient continues to have low back pain that radiates to the left lower extremity. On examination, ROM of the lumbar is decreased. Lasegue's, Bragard's and Kemp's test were all positive. There is weakness of the bilateral lower extremities. Examination performed on January 4, 2011, showed decreased sensation in the posterolateral thighs to the posterolateral calves. This request is for an appeal for EMG/NCV of the bilateral lower extremities. This patient had an MRI which showed protrusion that produces encroachment on the left L4 nerve root. Radiculopathy has been established clinically and by the MRI findings. EMG's are not necessary if radiculopathy is already clinically obvious. The medical necessity is not determined at this time. Based on the clinical information submitted for this review and using the evidence based, peer reviewed guidelines referenced above, this request for appeal for EMG/NCV of the bilateral lower extremities is not certified."*

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

The radiculopathy has been clinically established and confirmed with MRI and there is no need for an EMG/NCS. ODG specifically states: "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.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES