

# CASEREVIEW

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Notice of Independent Review Decision

**DATE OF REVIEW:** September 4, 2011

**IRO CASE #:**

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

EMG/NCV of bilateral lower extremities.

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

This physician is Board Certified Physical Medicine and Rehabilitation physician with over 15 years of experience.

**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**

**July 8, 2009:** Ms. was evaluated by Dr. MD, F.A.A.D.E.P., who diagnosed her with complex regional pain disorder, status post fusion of the Lisfrank joint and Status post removal of the painful hardware at the Lisfranc joint. He prescribed her Vicodin, Lyrica and recommended Myoflam gel and Antiflam gel to decrease the amount of oral pain medications.

**August 6, 2009:** Ms. was evaluated by Dr. who diagnosed her with lumbar radiculitis. He refilled her prescriptions and recommended Myoflam gel and Antiflam gel to decrease the amount of oral pain medications.

**November 4, 2009:** Ms. was evaluated by Dr. who diagnosed her with right foot pain, complex regional pain syndrome and chronic pain syndrome. He refilled her prescriptions and recommended Myoflam gel and Antiflam gel to decrease the amount of oral pain medications.

**January 6, 2010:** Ms. was evaluated by Dr. who diagnosed her with right foot pain, complex regional pain syndrome and chronic pain syndrome. He noted that he deferred performing any injections or surgical intervention. He refilled her prescriptions and recommended Myoflam gel and Antiflam gel to decrease the amount of oral pain medications.

**April 7, 2010:** Ms. was evaluated by Dr. who diagnosed her with right foot pain, complex regional pain syndrome and chronic pain syndrome. He noted that he deferred performing any injections or surgical intervention. He prescribed her Cymbalta and refilled her prescriptions and recommended Myoflam gel and Antiflam gel to decrease the amount of oral pain medications. A Manual Muscle Testing and Range of Motion test were performed which revealed Lower extremity ROM- ankle plantar flexion was -5 degrees on the left and -19 degrees on the right. Ankle dorsi flexion: -2 degrees on the left and -11 degrees on the right. Muscle test- Ankle Plantar flexion (knee flexed) Left 3 lbs, right 16lb= 81% difference; Ankle Dorsi flexion/inversion: left 1 lb, right 15 lbs= 93% difference; Foot Inversion: 2 lbs left, 10lbs right = 80% difference. Foot Eversion: 5 lbs left, 8 lbs right = 38% difference.

**May 5, 2010:** Ms. was evaluated by Dr. who diagnosed her with right foot pain, complex regional pain syndrome and chronic pain syndrome. He discontinued Cymbalta and increased Lyrica from 100 mg to 150 mg. He continued her on Vicodin and a transdermal compounding gel.

**June 2, 2010:** Ms. was evaluated by Dr. who diagnosed her with right foot pain, complex regional pain syndrome and chronic pain syndrome. He increased her Vicodin to 7.5/750 mg, continued the Lyrica 150 mg and recommended Myoflam gel and Antiflam gel to decrease the amount of oral pain medications.

**August 3, 2010:** Ms. was evaluated by Dr. who diagnosed her with right foot pain, complex regional pain syndrome and chronic pain syndrome. He referred her to an orthopedic surgeon due to spinal cord implant malfunction consultation due to having increased pain which causes sharp stabbing, aching pain to her low back due to where the spinal cord stimulator implant is located. He continued her Vicodin 7.5/750 mg, continued the Lyrica 150 mg and recommended Myoflam gel and Antiflam gel to decrease the amount of oral pain medications.

**September 30, 2010:** Ms. was evaluated by Dr. who diagnosed her with right foot pain, complex regional pain syndrome and chronic pain syndrome and status post fusion of right foot. He continued her Vicodin 7.5/750 mg, continued the Lyrica 150 mg and provided prescriptions for Lidoderm patches 5% and Cymbalta 30 mg and recommended Myoflam gel and Antiflam gel to decrease the amount of oral pain medications. A Manual Muscle Testing and Range of Motion test were performed which revealed Lower extremity ROM- ankle plantar flexion was -17 degrees on the left and -29 degrees on the right. Ankle dorsi flexion: 0 degrees on the left. Muscle test- Ankle Plantar flexion (knee neutral) Left 4 lbs, right 14 lbs= 71% difference; Ankle Dorsi flexion/inversion: left 5 lb, right 4 lbs= 20% difference; Foot Inversion: 1 lb left, 9lbs right = 89% difference. Foot Eversion: 3 lbs left, 11 lbs right = 73% difference.

**November 23, 2010:** Ms. was evaluated by Dr. who diagnosed her with right foot pain, complex regional pain syndrome and chronic pain syndrome and status post fusion of right foot. He continued her Vicodin 7.5/750 mg, continued the Lyrica 150 mg and provided prescriptions for Lidoderm patches 5% and Cymbalta 30 mg and recommended Myoflam gel and Antiflam gel to decrease the amount of oral pain medications. She was discharged in stable condition.

**January 20, 2011:** Ms. was evaluated by Dr. MD who diagnosed her with right foot pain, complex regional pain syndrome and chronic pain syndrome, status post fusion of right foot status post open rotator cuff repair, bankart lesion, and adhesive capsulitis of the right glenohumeral joint. He continued her Vicodin 7.5/750 mg, continued the Lyrica 150 mg and provided prescriptions for Lidoderm patches 5% and Cymbalta 30 mg and recommended Myoflam gel and Antiflam gel to decrease the amount of oral pain medications. A Manual Muscle Testing and Range of Motion test were performed which revealed Lower extremity ROM- ankle plantar flexion was -13 degrees on the left and -20 degrees on the right. Ankle dorsi flexion: -19 degrees on the left and -19 degrees on the right, Knee extension was at 0 degrees. Muscle test- Ankle Plantar flexion (knee neutral) Left 11 lbs, right 1 lbs= 91% difference; Ankle Dorsi flexion/inversion: left 26 lb, right 1 lb= 96% difference; Foot Inversion: 10 lbs left, 1 lb right = 90% difference. Foot Eversion: 7 lbs left, 1 lb right = 86% difference.

**March 17, 2011:** Ms. was evaluated by Dr. MD who diagnosed her with right foot pain, complex regional pain syndrome right lower extremity, chronic pain syndrome, status post fusion of right foot status post open rotator cuff repair, bankart lesion, and adhesive capsulitis of the right glenohumeral joint. He continued her Vicodin 7.5/750 mg, continued the Lyrica 150 mg and provided prescriptions for Lidoderm patches 5% and Cymbalta 30 mg. A Manual Muscle Testing and Range of Motion test were performed which revealed Lower extremity ROM- ankle plantar flexion was -6 degrees on the left and -39 degrees on the right. Ankle dorsi flexion: -19 degrees on the left and 0 degrees on the right, Knee extension was at -19 degrees. Muscle test- Ankle Plantar flexion (knee flexed) Left 12 lbs, right 1 lb= 92% difference; Ankle Dorsi flexion/inversion: left 8 lb, right 1 lb= 88% difference; Foot Inversion: 10 lbs left, 1 lb right = 90% difference. Foot Eversion: 5 lbs left, 1 lb right = 80% difference.

**June 15, 2011:** Ms. was evaluated by Dr. MD who diagnosed her with right foot pain, complex regional pain syndrome right lower extremity, chronic pain syndrome, status post fusion of right foot status post open rotator cuff repair x 2, status post bankart lesion repair x 2, and adhesive capsulitis of the right glenohumeral joint. He continued her Vicodin 7.5/750 mg, continued the Lyrica 150 mg and provided prescriptions for Lidoderm patches 5% and Cymbalta 30 mg. He referred her to Dr. for her right shoulder and right ankle. A Manual Muscle Testing and Range of Motion test were performed which revealed Lower extremity ROM- ankle plantar flexion was 0 degrees on the left and -33 degrees on the right. Ankle dorsi flexion: 0 degrees on the left and -13 degrees on the right. Muscle test- Ankle Plantar flexion (knee flexed) Left 30 lbs, right 2 lb= 93% difference; Ankle Dorsi flexion/inversion: left 15 lb, right 2 lb= 87% difference; Foot Inversion: 15 lbs left, 2 lb right = 87% difference. Foot Eversion: 10 lbs left, 2 lb right = 80% difference.

**July 8, 2011:** Ms. was examined by Dr. The examination revealed possible adhesive capsulitis of the right shoulder, rotator cuff tear, tendinopathy, AC arthropathy and bursitis. He recommended a CT scan of the right shoulder, steroid injection to the right shoulder and prescribed her Medrol Dosepak gel and Mobic. Ultrasound of the right shoulder revealed scar tissue, bursitis and possible rotator cuff tear.

**July 26, 2011:** M.D. performed an UR on the claimant. Rationale for Denial: There is minimal justification for performing nerve conduction studies when a claimant is presumed to have symptoms on the basis of radiculopathy.

**August 3, 2011:** M.D. performed an UR on the claimant. Rationale for Denial: On examination, there is no neurological deficit or notable changes of the foot or skin. There are no x-rays or other diagnostic studies submitted for review.

### **PATIENT CLINICAL HISTORY:**

The claimant's past medical history includes: diabetes mellitus controlled with medications and positive for hypertension.

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

The previous decisions are upheld. Per the medical records provided there was no documentation of a neurological examination, no evidence of color or temperature change, no record of SLR testing, and no record of DTR testing. Based on a lack of clinical radiculopathy findings an EMG/NCV is not recommended.

**ODG:**

Recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies. The later development of sympathetically mediated symptomatology however, has no pathognomonic pattern of abnormality on EMG/NCS. ([Colorado, 2002](#))

Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. See also [Monofilament testing](#). For more information and references, see the [Carpal Tunnel Syndrome Chapter](#). Below are the Minimum Standards from that chapter.

**Minimum Standards for electrodiagnostic studies:** The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards:

- (1) EDX testing should be medically indicated.
- (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for “screening purposes” rather than diagnosis are not acceptable.
- (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis.
- (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed.
- (5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted.
- (6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression.
- (7) In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. ([AANEM, 2009](#))

**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)