

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: December 14, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Urgent EMG of the Bilateral of the Lower Extremities Lumbar

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

This physician is Board Certified in Physical Medicine and Rehabilitation with over 16 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

10/09/12: Evaluation
10/19/12: UR performed
10/23/12: Physical Therapy note
10/26/12: Physical Therapy note
10/29/12: Physical Therapy note
10/29/12: Letter
11/20/12: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

On October 9, 2012, the claimant was evaluated for left sided low back, hip and leg pain. It was reported that on xx/xx/xx the claimant was working and fell twisting her low back. She was seen who thought her pain was consistent with trochanteric bursitis and adductor muscle strain and recommended an MRI of her hip. The claimant had an MRI of the hip on 10/01/12 which showed mild

degenerative changes in the left hip but no tendon tear. Her pain was reported to start in the left buttock and go down the lateral thigh with occasional radiation, numbness, and tingling down to the left foot up to the leg and also some burning pain in the left buttock. Her pain was rated a 5/10. Current medication was listed as: Mobic, Synthroid, vitamins. On physical examination her strength was 5/5 except for knee extension, dorsiflexion, and plantar flexion on the left side which was 5-/5, EHL was 5/5. She had tenderness in the left piriformis. Her right ASIS was higher than the left. She had positive straight leg raise on the left and had some scoliosis. Diagnosis: 1. Left lumbar radiculopathy. 2. Left hip degenerative changes. Recommendations: 1. MRI of the lumbosacral spine to rule out lumbar radiculopathy. 2. EMG nerve conduction study of the left lower extremity to rule in lumbar radiculopathy. 3. Go to physical therapy, also working on McKenzie exercises on the hip.

On October 19, 2012, performed a UR. Rationale for Denial: The patient is a female who sustained an injury last xx/xx/xx, and experiences left lower extremity pain with a pain score of 5/10. On physical examination as per medical report dated 10/9/12, there is tenderness of the left piriformis, with note of decreased motor strength in knee extension, dorsiflexion and plantarflexion on the left graded 5-/5. The patient's right anterior superior iliac spine is noted to be higher than the left. The Straight Leg Raise Test is positive on the left. There is no indication in the medical report dated 10/9/12 that the patient has tried and failed conservative care measures, such as Physical Therapy, to substantiate the necessity of the requested service at this time. As per referenced guidelines, electromyograms are recommended as an option, and may be useful to obtain unequivocal evidence of radiculopathy, after one-month conservative therapy.

On October 29, 2012, wrote a letter on the claimant's behalf. He reported that at the time of the 10/9/12 evaluation, the claimant had not exhausted all conservative treatment. At the time of the last evaluation, it was recommended that she start a course of physical therapy two times a week for four weeks. It was also reported that the claimant underwent an MRI of the lumbar spine which showed mild disc bulge at L4-5. Based on the history, physical examination and relevant imaging, wanted to move forward with having the EMG of the left lower extremity.

On November 20, 2012, performed a UR. Rationale for Denial: It was determined by the Specialty Advisor that the proposed treatment did not meet medical necessity guidelines. The detailed report with an explanation of denial was not included in the records provided by TDI, nor any other party.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION: Denial of EMG/NCS is upheld/agreed upon. Per ODG Pain Chapter, submitted documentation does not indicate results/benefit/change with conservative care prior to embarking on Electrodiagnostic studies. Therefore, the request for Urgent EMG of the Bilateral of the Lower Extremities Lumbar is not found to be medically necessary.

PER ODG:

Pain Chapter:

Electrodiagnostic testing (EMG/NCS)	<p>Recommended EMG or NCS, depending on indications. 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) EMG and NCS are separate studies and should not necessarily be done together. In the Carpal Tunnel Syndrome Chapter it says that NCS is recommended in patients with clinical signs of CTS who may be candidates for surgery, but EMG is not generally necessary. In the Low Back Chapter and Neck Chapter, it says NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. 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.</p> <p>Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards:</p> <ol style="list-style-type: none">(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)
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Lumbar Chapter:

EMGs (electromyography)	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. See Surface electromyography .)
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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)**