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Notice of Independent Review Decision

DATE OF REVIEW: December 29, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right lower extremity EMG/NCV study.

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

Pain Solutions:

- Review (10/19/11)
- Utilization reviews (11/02/11 – 11/30/11)
- Office visits (12/07/11 – 12/12/11)

TDI:

- Utilization reviews (11/02/11 – 11/30/11)

[ODG has been utilized for the denials.](#)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was using a floor stripper on xx/xx/xx. The pad came loose and the machine forked and pulled him rapidly to the left. Initially, he noticed low back pain and later at lunch he noted left shoulder soreness and numbness in his left hand.

On October 19, 2011, M.D., evaluated the patient in order to address maximum medical improvement (MMI), impairment rating (IR) and the ability of the patient to return to work. The patient complained of low back pain which hurt with walking and pain and numbness in his left hand worse when lying down at night.

The patient also had worsening headaches, which he had from a previous head injury. The patient had returned to work at light duty on October 3, 2011, driving around several sites and doing inspection of the sites. He was working full-time at that time, but with light duty. He had a previous injury in xxxx, when he suffered a head contusion and low back injury and right shoulder injury. He stated that the back and the shoulder had basically resolved, but he had some continuing problems with the head injury residual.

The patient initially saw Dr. chiropractor and received four sessions of chiropractic manipulation. He had x-rays of the cervical spine, lumbar spine and left shoulder on September 15, 2011. The cervical spine x-rays showed straightening consistent with muscle spasm, moderate narrowing of the C5-C6 disc and prominent anterior spurring at C4, C5, C6 and C7 and posterior spurring prominently at C6 and C7. Additionally, there was moderate sclerotic degenerative change along the posterior and lateral elements at multiple levels of cervical spine. There was significant degenerative changes along the joints of Luschka at C5-C6, C6-C7 and lesser at C3-C4 and C4-C5. The lumbar spine showed normal disc heights, except a slight narrowing at L5 and S1. There was significant sclerotic degenerative change along the disc at L4-L5 and prominent anterior spurring at L4-L5. There was no compression fracture and the alignment was normal. The left shoulder x-rays showed moderate hypertrophic change along the acromioclavicular (AC) joint, otherwise normal. The patient also had a functional capacity evaluation (FCE) assessment dated September 22, 2011, suggesting that he was able to safely perform lifting and carrying and sedentary activities. The patient stated that he recently had a magnetic resonance imaging (MRI) of the lumbar spine and there was some type of disc abnormality, which he could not describe.

The patient had been taking Flexeril, Naprosyn, metoprolol, Plavix and aspirin. Examination revealed tenderness from C2 all the way through C7 with a trigger point spasm at the left supraspinous area. There was pain and increased tingling and numbness in the left arm on rotation of the neck. Spurling's test was found to be positive. The patient had significant tight hamstrings and missed the floor to toe touch by at least a foot. The straight leg raising (SLR) was positive bilaterally radiating to the mid lumbar back. There was vague tenderness in the shoulder, but there was a collapse of both shoulders on resisted abduction. There was dullness to sharp touch in the entire right leg and most of the left leg, except slight normal pinprick along the lateral lower left leg. There was some weakness in raising the toes. Dr. diagnosed cervical strain and left shoulder strain with left arm radiculitis, possibly radiculopathy, left rotator cuff injury and lumbar spine strain with lumbar radiculitis. He opined that the patient had not reached the MMI as further evaluation and therapy was required and recommended continuing light duty with restrictions of lifting over 15 lbs, bending, stooping, pushing, pulling, twisting, kneeling or squatting.

On November 2, 2011, the request for nerve conduction velocity study/electromyography of upper and lower extremities was denied with the following rationale: *"There is no indication for electrodiagnostic testing. Based on the mechanism of injury reported, his diagnosis is at best a sprain/strain injury. Additionally, paresthesia is not specific to any dermatomal distribution. Description provided is nonspecific."* The report indicates that an MRI of the lumbar spine was performed on October 4, 2011, with 2-mm disc protrusion at L3-L4 with 25% effacement of the neural foramina inferiorly, 3-mm posterior herniations at L4-L5 with abutment and 5% effacement of the thecal sac and

30% encroachment of the neural foramina inferiorly bilaterally and 2-mm posterior protrusion at L5-S1.

On November 30, 2011, the request for EMG/NCV of the upper and lower extremities was partially approved for EMG/NCV of left lower extremity.

Rationale: "At the present time, for the described medical situation, Official Disability Guidelines would support a medical necessity for an electrodiagnostic assessment of the left lower extremity. an electrodiagnostic assessment of the left lower extremity would be established as a medical necessity as a lumbar MRI obtained on October 4, 2011, revealed findings consistent with the presence of a disc bulge at multiple levels in the lumbar spine, and provide an objective assessment of the functional integrity of the lumbar spine nerve roots and peripheral nerves in the left lower extremity. An electrodiagnostic assessment of the upper extremities is not established. The above noted reference would not support a medical necessity for an electrodiagnostic assessment of the upper extremities when a cervical MRI is pending. An electrodiagnostic assessment is not a first line test in the assessment of spinal disorders. At the present time, only an electrodiagnostic assessment of the left lower extremity would appear indicated for the described medical situation.

On December 7, 2011, D.C., noted the patient continued to have neck pain radiating to the left forearm, sharp low back pain radiating to the legs, more pronounced to the left leg and left shoulder pain. The patient also had numbness and tingling in the left hand and foot region. Dr. recommended MRI of the cervical spine and left shoulder to rule out herniated disc (pending), EMG/NCV of the right lower extremity to rule out radiculopathy (pending) and an orthopedic evaluation.

On December 7, 2011, M.D., performed a trigger point and facet injection with Kenalog at the left infraspinatus tendon.

Per the medical necessity letter, Dr. recommended medical evaluation by Dr. who had diagnosed him with lumbar disc and had recommended EMG/NCV of the lower extremity. Dr. stated he had recommended EMG/NCV of bilateral lower extremities on November 17, 2011, since the patient had numbness and tingling in the feet, radiating pain in legs and weakness. Left lower extremity was approved; Dr. requested reconsideration on November 21, 2011, of which right lower extremity was not approved. Based on the patient's associated symptoms, aggravating factors, and the medical recommendations, the EMG/NCV of bilateral lower extremity test was medically necessary due to the compensable injury the patient sustained on xx/xx/xx.

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

The findings on MRI are consistent with a chronic aging process and not an acute injury. The physical exam notes a positive straight leg raise with pain in the mid lower back. However, a positive straight leg raise occurs between 30 and 70 degrees traveling down the lower extremity in the sciatic distribution, which was not the case here. There is no evidence to support the need for an EMG/NCS of the right lower extremity and is not supported by ODG.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES**