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Notice of Independent Review Decision

DATE OF REVIEW: 6/19/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of EMG/NCS LLE (99243/pnr) 95860, 95900, 95904, 95903, 94934, 95936.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of EMG/NCS LLE (99243/pnr) 95860, 95900, 95904, 95903, 94934, 95936.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, this injured with repetitive bending, stooping, and heavy lifting are required for his work. The first or earliest record I have for review is dated xxxxx and is an emergency room note from xxxx xxxx. The note indicated that the worker had injured his back. X-rays were said to show narrowing of the disk spaces at L4-5 and L5-S1. The next note I have is from an unknown provider and is dated. The note indicated that back pain had begun eight days prior to that visit and that the working diagnosis was sciatica. Diclofenac, heat, massage, and stretching exercises were recommended. A note, again from an unknown provider, dated indicated that the injured worker was doing much better, had no tenderness, had complete range of motion, and had symmetrical reflexes. The plan was for the injured worker to return to work without restriction.

On January 14, 2012, a note from room indicated the injured worker was experiencing recurrent pain with numbness in the left leg. He apparently was given Vicodin and Robaxin. He returned to the emergency room on January 16, 2012 with difficulty walking and continued pain.

On January 18, 2012, R.N. FMP, evaluated the worker and diagnosed a lumbar radiculopathy. She recommended an MRI scan and referral to neurosurgery.

An MRI of the lumbar spine was performed on January 30, 2012, showing multi-level degenerative changes.

On February 1, 2012, a note entitled "History and Physical" was provided. The provider of the note is not identified although it appears to be, M.D. The provider noted that the worker had developed severe lower back pain on xxxxx. He had radiation of the pain to the hip and left lower extremity all the way to the foot. The pain was aggravated by coughing, sneezing, bending, stooping, sitting, and standing. The leg felt numb and weak. Deep tendon reflexes were 2+ and equal. Straight leg raising was positive at 30° on the left. Sensation was intact. There was give-away weakness in the left lower extremity. Epidural steroid injections were recommended.

On February 8, 2012, a physical therapy evaluation was performed. The injured worker had therapy sessions on February 21, 22, 24, 25, 29, and March 2 and 8.

On February 8, 2012, an unknown provider evaluated the worker and stated that leg pain had improved substantially and that the worker felt he could go back to work in "several weeks." The worker was cleared to return to work on April 1.

On March 23, an unknown provider reported that the patient's pain had recurred while sitting on bleachers. A CT scan and myelogram were recommended.

A CT scan and myelogram were performed on April 10. These showed a narrow canal on a developmental basis with degenerative changes in the spine. At L2-3, significant disk protrusion, spinal stenosis, and neural foraminal compromise were described. At L3-4, there was a diffuse disk protrusion with compromise of the L3 nerve root bilaterally. At L4-5, there was retrolisthesis with disk protrusion and L4 nerve root compromise, particularly on the left. At L5-S1, there was disk protrusion with no significant compromise of the thecal sac or foramen.

On April 16, an unknown provider reported that the worker had had a CT and myelogram and had been diagnosed with herniated nucleus pulposus at L2-3, L3-4, and L4-5. Weakness in the left iliopsoas and quadriceps muscles was described. The provider noted that epidural steroid injections had helped only a short while. Electromyographic studies were recommended.

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

Recommended denial of the requested services. This worker had an injury to his lower back and developed back pain with radicular symptoms in the left lower extremity. There is no accurate description of sensory loss pattern, but weakness was described as being localized in the iliopsoas and quadriceps muscle. Deep tendon reflexes were said to be normal. Straight leg raising was said to be positive at 30° on the left.

Imaging studies have demonstrated multi-level degenerative disk disease with spinal stenosis and foraminal compromise at multiple levels. Reports suggest that multiple nerve roots may be compromised and EMG would be helpful in documenting not only the presence of radiculopathy, but also what nerve roots are being objectively compromised. The reason for requesting nerve conduction studies is not clear in this medical record. According to the available records, the injured worker has no reported medical condition which would cause or be associated with a peripheral neuropathy.

The American Association of Electrodiagnostic Medicine, Mini Monograph number 32, a monograph on radiculopathies, does note that nerve conduction velocities are occasionally abnormal in a radiculopathy if the radiculopathy causes axonal loss and reduction in amplitude of the compound muscle action potential. The monograph further states that amplitudes of sensory nerve action potentials can sometimes be helpful in distinguishing radiculopathy from non-traumatic plexopathy. In this particular instance, there does not appear to be a question of whether or not the injured worker's symptoms are due to plexopathy versus radiculopathy versus peripheral neuropathy.

ODG Treatment Guidelines do not recommend nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. In general, unless there is a question of some peripheral nerve lesion other than radiculopathy (and there are no indications in this medical record that there is such a question) it is not recommended that nerve conduction studies be performed to confirm the presence of radiculopathy.

References:

1. ODG Treatment Guidelines
2. AAEM Mini Monograph number 32, authored by xxxxx, M.D. and xxxx xxxx, M.D.

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)**

AAEM Mini Monograph number 32, authored by Asa Wilbourn, M.D. and Michael Aminoff, M.D.