

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: July 10, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

NCV Bilateral Lower Extremity 95886x2 95903x4 95904x6 95934x2 and EMG Bilateral Lower Extremity 95886x2 95903x4 95904x6 95934x2

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

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

REVIEW OUTCOME:

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

Overturned (Disagree)

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:

04/03/01: X-rays Lumbosacral Spine interpreted by MD
04/03/01: MRI Lumbar Spine interpreted by MD
11/22/02: MRI Lumbar Spine interpreted by MD
02/14/03: CT Lumbar Spine post Discogram interpreted by MD
12/02/03: Clinical Note by MD with Southwest Neuroscience and Spine Center
12/15/03: Chest X-ray interpreted by MD
12/17/03: Lumbar X-rays interpreted by MD
12/17/03: Operative Report by MD
01/29/04: Lumbar X-rays interpreted by MD
02/04/04: Initial Physical Therapy Evaluation by PT with
02/04/04, 02/05/04, 02/06/04, 02/10/04, 02/11/04, 02/12/04, 02/17/04, 02/18/04,
02/19/04, 02/23/04, 02/25/04, 03/02/04, 03/03/04, 03/04/04, 03/09/04, 03/10/04,
03/11/04, 03/23/04, 03/24/04, 03/26/04, 03/29/04, 03/30/04, 04/02/04, 04/06/04,
04/07/04, 04/08/04, 04/12/04, 04/13/04, 04/14/04, 04/20/04, 04/22/04, 04/27/04,

04/29/04, 05/04/04, 05/07/04, 05/11/04, 05/14/04, 05/19/04, 05/20/04, 05/21/04:
Daily Physical Therapy Notes from Health (42 sessions)

04/06/04: Lumbar X-rays interpreted by MD

04/06/04: Clinical Note by MD with Neuroscience and Spine Center

05/12/04: Initial Evaluation by MD with Neuroscience and Spine Center

06/15/04: Re-evaluation by MD with Neuroscience and Spine Center

06/21/04: Initial Physical Therapy Evaluation by PT with

06/21/04, 06/24/04, 06/25/04, 06/30/04, 07/01/04, 07/02/04, 07/06/04, 07/08/04,
07/09/04, 07/12/04, 07/15/04, 07/19/04, 07/22/04, 07/23/04, 07/26/04, 07/27/07:
Daily Physical Therapy Notes from (16 sessions)

07/27/04: Re-evaluation by MD with Neuroscience and Spine Center

10/25/04: Re-evaluation by MD with Neuroscience and Spine Center

10/26/04: Lumbar X-rays interpreted by MD

10/26/04: Clinical Note by MD with Neuroscience and Spine Center

11/08/04: Initial Therapy Evaluation by PT with

11/08/04, 11/10/04, 11/12/04, 11/17/04, 11/18/04, 11/19/04, 11/22/04, 11/23/04,
11/24/04, 11/30/04, 12/01/04, 12/02/04, 12/07/04, 12/08/04, 12/09/04, 12/15/04,
12/16/04, 12/17/04, 12/20/04, 12/21/04, 12/22/04, 12/29/04, 12/30/04, 01/04/05,
01/06/05: Daily Physical Therapy Notes from (25 sessions)

12/03/04: Re-evaluation by MD with Neuroscience and Spine Center

02/08/05: Re-evaluation by, MD with Neuroscience and Spine Center

03/08/05: Procedure Note by, MD

04/07/05: Re-evaluation by, MD with Neuroscience and Spine Center

05/17/05: Lumbar X-rays interpreted by, DO

05/17/05: Clinical Note by, MD with Neuroscience and Spine Center

06/16/05: Re-evaluation by MD with Neuroscience and Spine Center

09/21/05: Re-evaluation by, MD with Neuroscience and Spine Center

10/24/05: Re-evaluation by MD with Neuroscience and Spine Center

12/13/05: Re-evaluation by MD with Neuroscience and Spine Center

04/19/06: Re-evaluation by MD with Neuroscience and Spine Center

06/14/06: Re-evaluation by MD with Neuroscience and Spine Center

09/13/06: Re-evaluation by MD with Neuroscience and Spine Center

09/25/06: 7 View Lumbar X-rays of Lumbar Spine interpreted by, MD

09/25/06: MRI Lumbar Spine interpreted by MD

09/27/06: Re-evaluation by MD with Neuroscience and Spine Center

12/14/06: Clinical Note by MD with Neuroscience and Spine Center

12/19/06: Clinical Note by MD with Neuroscience and Spine Center

01/23/07: Re-evaluation by MD with t Neuroscience and Spine Center

03/05/07: Peer Review by, MD

05/23/07: Re-evaluation by MD with Neuroscience and Spine Center

09/20/07: Re-evaluation by MD with Neuroscience and Spine Center

01/17/08: Re-evaluation by MD with Neuroscience and Spine Center

05/15/08: Re-evaluation by MD with Neuroscience and Spine Center

06/13/08: Independent Medical Review by MD

09/19/08: Re-evaluation by MD with Neuroscience and Spine Center

12/19/08: Re-evaluation by MD with Neuroscience and Spine Center

03/20/09: Re-evaluation by MD with Neuroscience and Spine Center

06/25/09: Re-evaluation by MD with Neuroscience and Spine Center
09/02/09: DEC Evaluation by MD with Disability Evaluating Center
09/28/09: Re-evaluation by MD with Neuroscience and Spine Center
11/09/09: Re-evaluation by MD with Neuroscience and Spine Center
12/11/09: Re-evaluation by MD with Neuroscience and Spine Center
01/14/10: Re-evaluation by MD with Neuroscience and Spine Center
02/12/10: Re-evaluation by MD with Neuroscience and Spine Center
05/13/10: Re-evaluation by MD with Neuroscience and Spine Center
07/28/10: DEC Evaluation by MD with Disability Evaluating Center
08/16/10: Letter from MD to RN, MPH, COHN/SCM
11/09/10: Letter from, MD to RN, MPH, COHN/SCM
11/09/10: Re-evaluation by MD with Neuroscience and Spine Center
05/17/11: Re-evaluation by MD with Neuroscience and Spine Center
07/27/11: DEC Evaluation by Melburn MD with Disability Evaluating Center
09/26/11: Re-evaluation by MD with Neuroscience and Spine Center
01/31/12: Re-evaluation by MD with Neuroscience and Spine Center
03/05/12: Re-evaluation by MD with Neuroscience and Spine Center
05/07/12: Re-evaluation by MD with Neuroscience and Spine Center
05/15/12: UR performed by MD
06/12/12: UR performed by MD
06/27/12: Carrier Submission

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx while unloading materials for the kitchen. She was lifting and bending and developed lower back pain. She has a previous history of injuries to her neck and back in xxxx and xxxx. She is status post 360 ALIF at L5-S1 on December 17, 2003.

On April 3, 2001, MRI of the Lumbar Spine, Impression: 1. There is partial lumbarization of Sa. There is a sclerotic pseudoarticulation in the right sacral ala relates to this partial lumbarization. 2. No significant spinal or neural foraminal stenosis is identified.

On November 22, 2002, MRI of the Lumbar Spine, Impression: Normal Study.

On February 14, 2003, CT Lumbar Spine, Impression: Fairly unremarkable post discogram CT scan.

On December 17, 2003, Operative Report by MD. Preoperative Diagnosis: Degenerative discogenic syndrome L5-S1. Procedure: Anterior lumbar fusion with posterior fixation L5-S1.

On April 6, 2004, X-rays of the Lumbar Spine, Impression: The patient has pedicle screws and posterior fusion plates at L5-S1. There is bony graft material at this level. The graft material shows incomplete union. It is held in place by an anterior compression screw. The patient has a Grade I anterior listhesis of L5 on

S1. The remainder of the lumbar spine shows normal alignment with no other bony abnormality appreciated.

On May 12, 2004, the claimant was evaluated by MD who reported she noted the ALIF L5-S1 360 degree surgery helped her quite a bit, but she still had pain in her back going across the buttock and occasionally into the left leg. On exam motor was 4/5 bilateral knee flexion, 4+/5 bilateral knee extension. Sensory was slight pinprick decrease at L4 on the left. Reflexes were 2+/4 with down going toes.

On June 15, 2004, the claimant was re-evaluated by MD who reported she couldn't complete her PT because she had been diagnosed with breast cancer at the end of May and had a partial mastectomy in early June. Dr. wanted her to resume PT.

On December 3, 2004, the claimant was re-evaluated by MD who reported she was undergoing treatment for breast cancer and had finished chemotherapy and radiation. She continued to have back pain, but was helped by methadone. She also noted some lower extremity weakness and lack of coordination. On examination she did show some weakness over-all in the lower extremities without masses or spasms.

On March 8, 2005, the claimant underwent bilateral SI joint injections by MD.

On May 17, 2005, X-rays of the Lumbar Spine, Impression: Evidence of posterior L5 laminectomy with fusion and approximately 5 mm of L5 anterolisthesis on S1 which is stable in all views.

On September 21, 2005, the claimant was re-evaluated by, MD who reported she was having more pain and more weakness in primarily her right leg and states she was having more balance problems. On exam her gait was antalgic favoring the right lower extremity. Reflexes were ¼ at the knees and ankles. Toes were down going. Straight leg raising was positive on the right. There was tenderness over the lumbosacral region. Dr. increased her Duragesic strength.

On September 13, 2006, the claimant was re-evaluated by MD who reported she had not had a MRI since her 360 degree ALIF at L5-S1 and that she continued to lose weight and was down 123 pounds. She continued to use Duragesic 75-mcg patches and Lyrica 75 mg. The claimant reported she felt she was losing muscle strength in the right leg and it seemed to give way on her. She had some fall the prior three months and sustained rib fractures and a broken nose. On exam she had an antalgic gait favoring the right lower extremity. Reflexes were always brisk at 2/4 in the lower extremities, but were hypoactive to ¼ in the lower extremities. Muscle strength was significantly decreased on the right side. Right knee flexion and extension, ankle dorsiflexion and plantar extension were 4-/5; left side is 4/5. Dr. recommended a lumbar MRI as well as seven-view x-rays.

On September 25, 2006, MRI of the Lumbar Spine, Impression: 1. Post operative changes at L4-5 without evidence of recurrent disc herniation or significant post operative complication. 2. No significant extradural or intradural findings observed.

On May 15, 2008, the claimant was re-evaluated by, MD who reported she had more problems with right lower extremity numbness and had some falls. On exam she had an antalgic gait and ambulated with a quad cane, favoring the left lower extremity. There was decreased sensation in the L5 distribution and in the top of the foot. Reflexes were ¼ at the knees and 2/4 at the ankles. There was no footdrop. Dr. continued Duragesic Patches and Lyrica and prescribed Norco for breakthrough pain.

On May 13, 2010, the claimant was re-evaluated by MD who reported she still had numbness and paresthesias in the lower extremities and secondary myofascial pain. It was noted she was titrated off her narcotics at the request of WC, but because of the pain, she could not go lower on the Lyrica or Cymbalta. She was also taking Ultram. On exam she ambulated with a quad cane. There was chronic weakness in right knee flexion and extension at 4/5, as well as ankle dorsiflexion and plantar flexion. Reflexes were ¼ at the knees and ankles. She had tenderness throughout the lumbosacral region.

On May 17, 2011, the claimant was re-evaluated by MD who reported her low back pain was localized and was at a 10. She also had some radiculopathy at times to the right. She reported she had fallen 4 to 5 times in the past year and a half and felt that during that is when all her problems really exacerbated. She stated she was having problems sleeping, coughing and sneezing because it caused excruciating pain. On exam her gait was antalgic using a cane. Motor was 4/5 right ankle dorsiflexion, plantar flexion, and knee flexion; 4/5 left ankle dorsiflexion, all other areas 5/5. Reflexes were 1+/4, 0/4 in the ankles. Sensation showed decreased pinprick in an L5-S1 distribution on the left compared to the right. Sitting straight leg raise testing and Patrick's testing were negative bilaterally. She was continued on Cymbalta, Lyrica, and Ultram until she could be re-evaluated by Dr..

On March 5, 2012, the claimant was re-evaluated by, MD who reported she was back on Duragesic 50 mcg patches which helped her function. On exam her gait was symmetrical. Motor was 4/5 right ankle dorsiflexion and plantar flexion, other areas 5/5. She had decreased pinprick in an L5 distribution on the right, less so on the left. Reflexes were 1+/4 knees, 0/4 ankles. Sitting straight leg raise testing and Patrick's testing were negative bilaterally.

On May 7, 2012, the claimant was re-evaluated by MD who reported she noticed more pain going down her legs, especially the left leg. On exam her gait was symmetrical. Motor was 4-/5 right ankle dorsiflexion and plantar flexion, other areas 5/5. She had decreased pinprick in an L5 distribution on the right, slightly decreased on the left. Reflexes were 0/4 knees and ankles. Sitting straight leg

raise testing and Patrick's testing were negative bilaterally. Tenderness was noted bilaterally in the lumbosacral regions without masses or spasms. Diagnosis: Lumbar post-laminectomy syndrome and chronic lower extremity radiculopathy, getting somewhat worse since her last visit. Plan: MRI of her lumbar spine and bilateral lower extremity electrodiagnostic studies. She was kept on Duragesic 50 mcg patches.

On May 15, 2012, MD performed a UR. Rationale for Denial: The progress note dated 05/07/12 more pain going down her legs, especially the left leg. Exam indicates motor strength 4-/5 right ankle dorsiflexion and plantar flexion, other areas 5/5. She has decreased sensation to pinprick in L5 distribution on the right, slightly decreased on the left. Reflexes 0/4 knees and ankles. Tenderness is noted bilaterally in the lumbosacral region without masses or spasms. EMG/NCV studies have been requested. The patient has been diagnosed with post laminectomy syndrome. She has ongoing symptoms and findings of lumbar radiculopathy. Electrodiagnostic studies are not necessary if radiculopathy is clinically obvious. Given that this patient has signs and symptoms of lumbar radiculopathy, the requested testing seem redundant. It is unlikely that the findings of the electrodiagnostic testing would impact the management.

On June 12, 2012, MD performed a UR. Rationale for Denial: The patient reported injury on xx/xx/xx and now has complaints of low back pain with radiation to the bilateral lower extremities, left greater than right. Official Disability Guidelines state EMG is recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy, after 1 month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The documentation provided indicated the patient had complaints of lower back pain with radiation to the bilateral lower extremities. The documentation also indicated the patient had decreased strength on right ankle dorsiflexion and plantar flexion and decreased sensation to pinprick in the L5 distribution. Reflexes were 0/4 in the knees and ankles bilaterally. However, there is insufficient documentation to indicate the need of an EMG of the bilateral lower extremities at this time as the patient has symptoms of radiculopathy and guidelines state EMGs are not necessary if radiculopathy is already clinically obvious. Additionally, it is unclear based on the documentation what recent conservative treatments have been initiated to include physical therapy, home exercise program or activity modification and efficacy in terms of reducing the patient's pain and increasing function. Furthermore, guidelines state nerve conduction studies are not recommended as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms of on the basis of radiculopathy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION: Denial of Bilateral LE EMG/NCV is overturned/disagreed with. ODG Pain Chapter recommends electrodiagnostic studies to establish diagnosis of nerve entrapment/irritation in cases with neurologic symptoms. In a matter of 2 months,

March to May 2012, there was increased LE pain, increased weakness in right ankle dorsiflexion and decrease in reflexes. Electrodiagnostic information may assist in diagnosis of etiology for new neurologic signs and symptoms and potentially change treatment plan if used as criteria for possible injection for pain management. The request for NCV Bilateral Lower Extremity 95886x2 95903x4 95904x6 95934x2 and EMG Bilateral Lower Extremity 95886x2 95903x4 95904x6 95934x2 is found to be medically necessary and meets ODG guidelines.

Per ODG:

<p>Electrodiagnostic testing (EMG/NCS)</p>	<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.
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	(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)
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.)
Nerve conduction studies (NCS)	Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. EMGs (electromyography) are 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.

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)