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Notice of Independent Review Decision

DATE OF REVIEW: March 23, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
EMG/NCV lower series

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Doctor of Chiropractic with 17 years of experience.

REVIEW OUTCOME

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

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Utilization reviews (02/20/12 – 02/29/12)

- Office visits (02/03/11 - 10/31/11)
- Diagnostics (02/03/11 - 08/19/11)
- Therapy (02/03/12 - 02/16/12)

- Office visits (12/10/10 – 03/08/12)
- Therapy (12/10/10 – 03/12/12)
- Diagnostics (02/24/11 -02/19/12)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female who was involved in a motor vehicle accident (MVA) on xx/xx/xx. The patient had a head-on collision with another vehicle. She was driving a bus when another vehicle turned right into her oncoming lane. The impact struck the front left area of her bus and she sustained severe whiplash injuries. Her head, neck and back area were thrown forward and backward and

side to side on initial impact. She was a restrained driver when the accident occurred.

She was admitted to emergency department and was given prescription for naproxen, Flexeril and Lortab.

On December 10, 2010, evaluated the patient for pain in her right lower neck, right shoulder, and right lateral side of low back area. She also had tingling in her right hand. noted the following history: *She was transported to North Hills Hospital emergency room (ER) by private transportation. X-rays were taken of her neck, shoulder and chest area. A computerized tomography (CT) scan was done of her head. She was examined and released to go and see her own treating doctor. No fracture was seen but she sustained severe whiplash injuries to her head and spinal area.* Currently, the patient had acute pain in the cervical, thoracic, and lumbar spine area with muscle spasm and nerve root compression. The assessment was concussion syndrome, cervical disc syndrome, thoracic facet syndrome, lumbar disc syndrome, shoulder derangement, nerve root compression and myofascitis.

From December 12, 2010, through December 2, 2011, the patient attended therapy under consisting of chiropractic manipulative therapy (CMT), electrical muscle stimulation (EMS), myofascial release and manual therapy. gave prescriptions for orthopedic shoulder and back brace, vitamin B complex, an exercise ball, pain patches, moist heating, pad, orthopedic inversion table, king's mattress, heel lift, analgesic cream, ice packs and shoulder straps.

On January 5, 2011, the patient was evaluated at for ongoing psychological state, specifically relating to her treatment progress. The treating physician expressed concern that the patient might not be receiving maximum benefit from her medical treatment as a result of possible behavioral health factors resulting from her injury that might be acting as barrier to her full recovery. The patient was noted to be participating in active and passive therapy, which she described as not helpful in decreasing her pain. The patient stated that her current symptomatology began at its current severity shortly after the accident and was directly related to the injury and associated difficulties. The primary problem with regard to returning to work was her pain and posttraumatic stress disorder (PTSD) symptoms from the accident in which the other driver was killed. The Beck Depression Inventory-II (BDI-II) score was 41, i.e., severe range for depression and Beck Anxiety Inventory (BAI) score was 34, suggestive of severe range of anxiety. The Fear Avoidance Beliefs Questionnaire score indicated significantly high degree of fear avoidance beliefs suggesting that the patient will require close supervision and behavioral health intervention during any physical therapy (PT) regimen in order to appropriately confront her fears of re-injury. The results of the assessment suggested that the patient was experiencing psychological distress due to concerns over her health as a result of her injury. The evaluator diagnosed adjustment disorder with mixed anxiety and depressed mood and recommended individual psychotherapy.

From January 17, 2011, through May 24, 2011, the patient attended 12 sessions of individual psychotherapy.

On January 24, 2011, the patient underwent diagnostic testing at Apex Imaging. MRI of the cervical spine was unremarkable. MRI of the thoracic spine showed a slightly, over 2-mm right posterior paracentral disc protrusion with a small associated tear at T7-T8 and a 1-cm markedly hypointense lesion along the right lateral posterior T1 vertebra with slight extension into the right pedicle, which appeared smoothly demarcated. MRI of the lumbar spine showed 1 to 2 mm posterolateral disc bulge bilaterally at L3-L4, 3-mm right posterolateral disc bulge/protrusion with a 2-mm left posterolateral disc bulge, and mild-to-moderate proximal neural foraminal stenosis bilaterally.

On February 3, 2011, performed electrodiagnostic studies which showed findings consistent with a right L5 radiculopathy.

pain management, who had previously also seen the patient, noted that the patient had some relief post first injection. But the pain had returned. The patient stated that she had no appetite, she wanted to get something to counter her depression and to allow her to not to be so sensitive and crying all the time. prescribed Xanax, Wellbutrin and amitriptyline.

On February 10, 2011, CT scan of the thoracic spine showed a 3-mm right paracentral disc protrusion at T7-T8 effacing the ventral thecal sac; calcified left hilar lymph nodes likely due to prior granulomatous infection, a couple of pulmonary nodules identified in the right apex, thyromegaly with heterogenous density and couple of hypodense lesions in the inferior isthmus and left thyroid lobe. Sclerotic focus in the T1 vertebral body likely represented a bone island, osteoblastoma was considered less likely.

On March 3, 2011, x-rays of the thoracic and lumbosacral spine were unremarkable.

On March 23, 2011, performed an impairment and functional capacity evaluation (FCE) and assessed range of motion (ROM) impairment rating of 25%.

On March 30, 2011, noted that the patient had pain radiated into her right leg and groin area and was sharp and achy and sometimes she had numbness of her right shoulder blade. There was also weakness noted in the arms and legs. The patient felt like there was a knife jabbing her in her back. She had electrical shock in the spine with muscle spasms. She also had bowel and bladder dysfunction and some progressive weakness and trouble walking. The patient has had ESIs by and the patient was on Lortab and Flexeril. felt that the patient had a right L5 and bilateral S1 radiculopathy. The patient stated that therapy was of no benefit. The patient was quite depressed and had major anxiety from the injury. She had insomnia with decreased interest, increased guilt, decreased energy, poor concentration, anorexia and decreased psychomotor activity. She experienced fear and horror and helplessness from the injury. She had feelings of no future and inability of love, indicating she had PTSD. assessed disc protrusions at L4-L5, L3-L4, C5-C6, and T7-T8, possible right rotator cuff and PTSD with depression and anxiety; prescribed Prozac and Soma, recommended to stop Wellbutrin, Elavil and Adderall and referred the patient to a psychiatrist, for PTSD and depression. The patient was not able to return to work.

On April 12, 2011, MRI of the right shoulder showed moderate tendinosis of the supraspinatus tendon without rotator cuff tear, mild subdeltoid bursitis and marrow edema versus incomplete fat saturation in the lateral clavicle associated with a questionable, nondisplaced lateral clavicular fracture.

On April 19, 2011, performed an EMG/NCV study that showed subtle electrophysiological evidence of lumbar radiculopathy involving the right L5 nerve root. Lumbar radiculopathy manifested in increased chronic reinnervation potential activity recorded in L5 innervated paraspinals and distal musculature within the right lower extremity.

From April through October 2011, maintained the patient on Prozac, Soma and Ultram.

On May 5, 2011, orthopedic surgeon, evaluated the patient for right shoulder pain. Examination showed limited motion, positive impingement signs, Neer impingement sign, Hawkins' sign, apprehension test and biceps load test. The patient had tenderness over the bicipital groove, much more over the anterior aspect of her shoulder. X-rays of the right shoulder was benign for relevant osseous abnormalities. assessed probable right labral tear, doubt distal clavicular fracture, prescribed Relafen and recommended MR arthrogram of the shoulder. On follow-up, noted that MR arthrogram showed subacromial bursitis and tendinopathy. He started the patient on rotator cuff strengthening and stretching program both in therapy as well as with a home exercise program (HEP).

In May 2011, neurosurgeon, evaluated the patient for neck pain, shoulder pain and lower back pain. He assessed intervertebral disc displacement in L5, probable intervertebral disc displacement at L3-L4, right L5 radiculopathy, intervertebral disc displacement at C5-C6, C6 radiculopathy, intervertebral disc displacement at T7-T8 with intervertebral body inclusion at T1, right rotator cuff tear or tendinosis by history, and PTSD with depression and anxiety. recommended a lumbar, thoracic and cervical myelogram with CT scan and possible surgical intervention.

On May 18, 2011, MRI of the right shoulder showed mild supraspinatus and infraspinatus tendinopathy.

On August 9, 2011, an FCE showed the patient's physical demand level (PDL) was light-medium.

On August 19, 2011, post lumbar myelogram CT scan showed questionable soft-tissue fullness in the right neural foramen of L4-L5.

On December 14, 2011, performed right L4-L5 laminectomy with discectomy, foraminotomy, osteophytectomy and medical facetectomy.

2012: From January 17, 2012, through March 12, 2012, the patient attended 11 postoperative therapy sessions consisting of EMS, ice, therapeutic exercises and manual therapy.

On February 16, 2012, performed an NCV study that showed electrophysiologic evidence of a possible right S1 radiculopathy.

On February 19, 2012, a pelvic-lumbar and sacroiliac (SI) sonographic scan showed the following: The posterior longitudinal ligament increased in its thickness L1, swelling accompanied by a moderate hyperechoic signal reflected at both the main body and the lateral extensions of the ligament. There were sonographic indications of joint inflammation demonstrated by increased reflection signals at the lumbar joint planes bilaterally at L4-L5. The lumbar spine's stabilizing muscles appeared swollen with localized type of edema.

On February 20, 2012, per utilization review, the request for EMG/NCV (lower series) was denied with the following rationale: "*In this case there are no recent medical records from the requesting provider that support the need for this study. It is reported that is also requesting spinal ultrasound and nerve conduction study though no rationale for these tests is provided."*

On February 20, 2012, noted he received a call from regarding NCV and ultrasound study to be performed on the patient's lumbar spine and lower extremities. stated she had decreased dermatomes in the right L3, L4, and L5 on the right and decreased strength with right hip flexors and right knee flexors on exam.

The next day stated that he had requested MRI of the lower back due to significant pain in her right lower back, buttock and right upper leg area. A one on one peer phone call was made with regarding this request.

On February 23, 2012, a reconsideration request was made for NCV and ultrasound testing.

On February 27, 2012, noted wanted the patient to complete 12 sessions of postoperative rehab before conducting EMG/NCV testing of the lumbar spine and lower extremities.

On February 29, 2012, the reconsideration request for the EMG/NCV (lower series) was denied with the following rationale: "*As it was so early post-operatively and that postop therapy has not been completed, the patient's current symptoms may improve with time and additional postop therapy. Additionally, even if this study were to show evidence of pathology, it would not likely change the current treatment protocol and that other treatment options, such as injection/surgery, would not likely be recommended/approved until she had completed her postop therapy. Hence, the medical necessity of the requested service is not substantiated at this time and as such, the previous non-certification is upheld."*

On March 1, 2012, stated he spoke to regarding the request for MRI with and without contrast of her lumbosacral area. He further stated that her neurological symptoms had worsened and the MRI was needed to see if there were new concerns in her lumbar spine like disc pathology, nerve root compression or spinal cord compression.

On March 7, 2012, the patient complained of inability to lay on her back or stomach. She had pain in her right low back area and right buttock area. noted subluxation in her right shoulder, lumbar spine and right SI area and muscle spasms in the lumbar spine and nerve compression in lumbar spine. prescribed a seat wedge cushion for her back and buttock pain and ice packs. The patient was treated with therapy including therapeutic exercises, CMT, manual therapy, and EMS/heat. Spinal Decompression with an IST table.

On March 8, 2012, noted that the patient had pain in her right hip area, right buttock and right upper thigh. He prescribed Norco and amitriptyline.

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

ODG Guidelines state; EMG's are not necessary if radiculopathy is already clinically obvious. Therefore, medical necessity has not been established.

The records reveal that is utilizing spinal decompression starting 6 weeks post op with 50 lbs and progressing to 65 lbs. This may be the cause of her increased pain and symptomatology.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**