SENT VIA EMAIL OR FAX ON
Apr/27/2012

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Apr/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Repeat EMG/NCV of Lower Extremities

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Orthopedic spine surgeon, practicing neurosurgeon

REVIEW OUTCOME:

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

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Cover sheet and working documents
Sensory nerve conduction threshold test and CPT evaluation results dated 03/21/01

Operative report for L3-4 bilateral decompressive lumbar laminectomy, complete discectomy with compression of thecal sac, posterior lumbar interbody fusion with autologous bone and AlloMatrix, bilateral internal fixation with Brantigan cages, bilateral pedicle screw fixation with XIA system, and bilateral intertransverse spine fusion with autologous bone and AlloMatrix dated 04/11/11perfomred by Dr.

Patient history and physical dated 04/11/11
Office visit notes Dr. dated 10/13/10-02/28/12
MRI lumbar spine dated 01/04/11
Peer review Dr. dated 02/20/11
Initial review adverse determination letter dated 03/12/12
Reconsideration adverse determination letter dated 03/29/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. Records indicate after failing a course of conservative treatment, the claimant underwent discectomy and posterior lumbar interbody fusion on 04/11/11. The patient continued to complain of low back pain radiating to lower extremities. MRI of lumbar spine dated 01/04/11 revealed postsurgical changes of interbody fusion with interbody fusion device and pedicle screws at L3 and L4. There is posterior central disc bulge at L1-2. There is posterior central mild disc protrusion at L4-5. There is posterior central and left paracentral disc protrusion at L2-3 with thecal sac impingement and mild central spinal canal narrowing. The claimant was seen on 02/28/12 complaining of low back pain radiating to lower extremities down to feet with pain level of 10+/10+. The claimant stated he did not want to take too many pills because they are not helping him. On examination the claimant had decreased range of motion of lumbosacral spine with spasm; deep tendon reflexes were decreased but equal; no gross motor deficit; straight leg raise positive at 40 degrees bilateral; decreased sensation in the distribution of L5-S1 nerve root bilateral. The claimant is noted to have had steroid injections to both knees on 02/14/12. He wants to have surgery in low back. The claimant was recommended to undergo MRI of lumbosacral spine and to have EMG/NCV of lower extremities.

Per adverse determination letter dated 03/12/12, a request for bilateral EMG/NCV of lower extremities was non-authorized. It was noted the claimant had L3-4 discectomy and interbody fusion utilizing AlloMatrix and Brantigan cages. There is bilateral pedicle fixation performed as well as intertransverse spinous fusion. It was noted EMG/NCS of lower extremities is not approved. There is no indication for repeat MRI based on previous lumbar MRI findings and/or previous exam findings. Pain level has remained the same, along with physical examination findings since 05/11. Physical examination on 02/28/12 reported decreased lumbar range of motion, symmetric reflexes, no gross motor deficits, straight leg raise positive bilaterally at 40 degrees, decreased sensation at L5-S1, and no measured atrophy of lower extremities.

Per adverse determination letter dated 03/29/12, the request for EMG/NCV of bilateral lower extremities was not authorized. The reviewer noted the claimant is a male who was injured on xx/xx/xx, but the medical records do not denote mechanism of injury. The claimant was diagnosed with lumbosacral radiculopathy, protruded disc at the level of L2-3, history of herniated propulsus nucleus L3-4 (post-operatively), and chronic pain syndrome of the lumbar spine. Subjective complaint by the claimant 02/28/12 was low back pain with radiation to the lower extremities down to the feet. The claimant rated his pain level at 10+/10+. He reported he did not want to take too many pills because they were not helping. He specified he was unable to sleep well due to the pain. He commented my back is just killing me. The physical examination findings revealed decreased range of motion of the lumbosacral spine with spasms. Deep tendon reflexes were decreased but equal. There were no gross motor deficits noted. Straight leg raise was positive at 40 degrees bilaterally. There was decreased sensation in the distribution of the L5-S1 nerve roots bilaterally. Calf circumference was 38.5cm left and 39.0cm right. Cranial nerve examination was within normal limits. The claimant had remained unauthorized to have requested pharmacotherapy. It was noted that this is a reconsideration for EMG/NCV that was non-certified based on medical records provided and previous EMG/NCV studies reporting no acute radiculopathy or active denervation as of 08/14/06. It was noted that guidelines indicate electrodiagnostic studies (needle, not surface) may be useful to obtain unequivocal evidence of radiculopathy after one month of lower levels of care, but EMG studies are not necessary if radiculopathy is already clinically obvious. NCV is not recommended for low back conditions. The records reflect the claimant had increasing back pain at 8+-10+/10. Physical examination demonstrated decreased range of motion, deep tendon reflexes decreased but equal and no gross motor deficits were noted with no atrophy in the dermatomal distribution. There was decreased sensation in the L5-S1 distribution bilaterally; however, with no motor deficits and no atrophy noted in this distribution. There were no medical notes reported any lower levels of conservative care prior to the request for electrodiagnostic studies.

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

Based on the clinical information provided, the request for repeat EMG/NCV of lower extremities is not supported as medically necessary. The claimant is noted to have sustained an injury on xx/xx/xx. He subsequently underwent surgical intervention on 04/11/01 with L3-4 decompressive laminectomy discectomy and posterior lumbar interbody fusion with pedicle screw fixation at the bilateral L3-4 level. The claimant was noted to continue to complain of low back pain radiating to the lower extremities down to his feet. Records indicate that previous EMG/NCV reported no acute radiculopathy or active denervation as of 08/14/06. Most recent examination revealed decreased sensation in the L5-S1 distribution bilaterally, but there were no motor or reflex changes. Given the current clinical data, medical necessity is not established for the proposed electrodiagnostic testing.

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

[ ] ACOEM-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)