Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 4/16/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of one EMG/NCV of the bilateral lower extremities.

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 disagrees with the previous adverse determination regarding the prospective medical necessity of one EMG/NCV of the bilateral lower extremities.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Records were received and reviewed from the following parties: MD and Management

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD:
LHL009 – 3/26/13
Management:
Appeal Review Denial – 3/14/13

Denial Letter – 2/21/13

MD:

Request for Reconsideration – 3/5/13
Follow-up Note – 1/9/13
Chart Note – 1/9/13
Interval History – 1/9/12

Records reviewed from Management:

MD:

MMI/Impairment Rating Addendum – 1/31/13
DDE Report – 6/22/12

Texas Department of Insurance:

Letter of Clarification – 1/30/13
Commissioner Order – 6/4/12
DWC1 – 3/1/10

Dr.:

Pre-authorization Requests – 2/5/13, 2/19/13

Hospital:

CT Lumbar Spine w/ Myelogram Report - Postmyelogram CT scan of the lumbar spine – 1/7/13
Lumbar Myelogram – 1/7/13
History & Physical – 10/8/12
MRI Lumbar Spine w/o – 1/28/11, 7/11/12
Three Views of the Lumbar Spine Report – 12/2/10
Rad/Lumbar Spine Complete w/Ben – 6/19/12, 10/14/11
Rad/Chest 2 Views – 6/14/11
Operative Report – 6/21/11
Discharge Summary for PT – 6/22/11
PT Evaluation – 6/22/11
Discharge Home-Care Instructions – undated
Procedure Note – 10/8/12

Pinnacle Pain Medicine:

Pre-authorization Requests – 9/6/12, 2/6/13
Office Visit Notes – 10/8/12, 1/17/13

MD:

Approval Letter – 5/24/11

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Pre-authorization Request – undated
Adverse Determination Letters – 6/21/10, 7/9/10, 11/19/10, 12/20/10, 3/16/11, 5/10/11, 10/18/12, 12/1/11, 12/8/11, 10/18/12, 11/5/12
Pre-authorization Approval Letters – 3/15/10 x2, 3/24/10, 4/21/10, 4/27/10, 6/14/10, 7/9/10, 1/13/11, 1/18/11, 5/26/11, 7/28/11, 8/9/11, 10/10/11, 10/19/11, 3/12/12, 6/18/12, 6/29/12, 9/10/12
Pre-authorization Partial Approval Letter – 8/15/11

Neurosurgical Consultant/ MD:

Pre-authorization Requests – 6/9/105/24/11, 10/6/11, 3/8/12, 6/13/12, 6/27/12, 10/16/12, 10/29/12, 11/19/12
PT Scripts – 7/25/11, 10/12/11
Appeal Letter – 5/17/11
Follow-up Notes – 6/16/10, 6/28/10, 7/19/10, 8/4/10, 9/1/10, 10/13/10, 11/10/10, 11/29/10, 12/2/10, 1/12/11, 2/17/11, 2/28/11, 4/27/11, 4/29/11, 5/2/11, 6/3/11, 7/25/11, 9/26/11, 10/17/11, 11/29/11, 2/22/12, 2/28/12, 3/8/12, 3/27/12, 4/17/12, 6/12/12, 6/19/12, 7/23/12, 8/29/12, 9/25/12, 10/10/12
Interval History Notes – 6/16/10, 6/28/10, 7/19/10, 7/25/11, 11/29/11, 10/17/11, 2/22/12, 2/28/12, 3/27/12, 4/17/12, 6/12/12, 6/19/12, 7/23/12, 8/29/12 9/25/12, 10/10/12
History and Physical – 6/20/11
Request for Reconsideration – 10/24/12
History, Physical and Neurological Examination – 5/26/10
Letter of Appeal – 6/23/10
Medical Conference Notes – 7/9/10, 12/17/10, 5/9/11, 12/1/11, 10/17/12, 11/1/12
Letters of Medical Necessity – 8/11/10, 11/18/10
DWC73 – 12/2/10, 2/28/11, 4/27/11, 5/2/11, 6/3/11, 7/25/11, 9/26/11, 11/29/11, 12/27/11, 1/24/12, 1/26/12, 2/22/12, 2/28/12, 3/27/12, 4/17/12, 6/12/12
Electrodiagnostic Medicine Consultation – 2/18/11
Procedure Note – 3/27/12
Chart Note – 6/20/12, 7/23/12

Institute for Rehabilitation:
Pre-authorization Requests – 7/28/11, 8/8/11, 10/17/11, 11/30/11
Pre-authorization Request – 11/30/11
Initial Evaluation – 8/8/11
Plan of Care – 8/8/11, 9/7/11
Daily Note – 11/15/11

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Retrospective Review Information Sheet – 8/12/11
Notice of Disputed Issue and Refusal to Pay Benefits – 12/16/11

Pharmacy:
Letter of Medical Necessity – 6/6/11

Parks Physical Therapy and Work Hardening Center:
Pre-authorization Request – 12/5/11

Rehabilitation:
Script – 11/30/11

RN:
History and Physical – 8/28/12

Group:
DDE Assignment Letter – 6/15/12

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DDE Summary – 6/15/12

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Associate Statement-Workers Compensation – 3/1/10
Associate Incident Log Form – 3/1/10
Requests for Leave of Absence – 8/9/10, 12/2/10, 12/12/11
Certification of Health Care Provider for Associate's Serious Health Condition – 6/21/10, 12/20/10
Job Offer – Temporary Alternative Duty – 3/1/10, 3/19/10, 4/7/10, 4/28/11, 12/5/11, 1/26/12
Temporary Alternative Duty Assignment – 4/18/12

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DWC73 – 3/1/10, 3/8/10, 3/10/10, 3/12/10, 3/19/10, 4/2/10, 4/7/10, 4/22/10, 5/5/10
Office Notes – 3/1/10, 3/8/10, 3/10/10, 3/12/10, 3/19/10, 3/22/10, 4/1/10, 4/2/10, 4/7/10, 4/22/10, 5/5/10
Visual Analogue Scale, Ransford Pain Drawing, & Pain Scale – undated
Physical Therapy-Progress Summary – date unclear
Prescription for Referral – 3/10/10, 4/23/10
Pre-authorization Request – 3/22/10, 4/19/10
Patient Information Sheet – 3/16/10
Physical Therapy Initial Evaluation – date unclear

One Source Diagnostic Imaging:

Radiological Examination Reports – 3/15/10, 4/30/10

Laboratories:

Lab Results – 6/18/10

Pain Management:

Lumbar Epidural Steroid Injection #1 – 6/21/10

Memorial Medical Center:

Emergency Visit Records – 5/24/07, 3/17/09, 4/20/09, 12/8/09, 7/7/10
Obstetrical Records – 11/1/07
Admission Records/Operative Notes – 5/14/09

Diagnostic Imaging:

Lumbar Myelogram and CT Report – 8/4/10

Management, Inc.:

Information Requests – 12/7/10, 9/27/11

Enterprises:

Surveillance Report – 3/1/11

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Surgical Pathology Report – 6/23/11

DWC69 – 6/22/12
LHL009 – 11/9/12

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured on xx/xx/xx when she stepped off a footstool and twisted the left ankle and lower back. She was treated with analgesics and physical therapy. On May 26, 2010 the worker was seen by Dr. who diagnosed lower back and bilateral leg pain, right worse than left, with diffuse central and slightly right-sided L5-S1 disc protrusion versus bulge, and right S1 radiculopathy. He recommended lumbar epidural steroid injections and an EMG.

Findings on EMG and nerve conduction studies on February 18, 2011 were reported to show evidence of right S1 radiculopathy, acute and sub-acute changes, with no evidence of left lumbosacral radiculopathy, and no electrodiagnostic evidence of distal polyneuropathy. Asymmetric absence of the right H reflex was also consistent with right S1 nerve root pathology.

On June 20, 2011, Dr. physical examination revealed weakness of the extensor hallucis longus and weakness of ankle dorsiflexion on the right with hypoesthesia in the L5 and S1 distribution. He diagnosed right S1 radiculopathy per electrophysiological studies, right L5 to S1 radiculopathy by physical examination.

On June 21, 2011 the worker went to surgery for decompressive right L5-S1 laminectomy with right L5-S1 partial medial facetectomy, lateral recess decompression, decompression of the right L5 and S1 nerve roots, excision of partially calcified L5-S1 disc protrusion, and L5-S1 discectomy, performed by Dr.

On the March 27, 2012 follow up visit the worker reported a two-week history of increasing back spasm radiating into the left lower buttock and posterior thigh. A Medrol Dosepak had helped. On examination, straight leg raising was positive bilaterally. There was hypoesthesia in the right L5 distribution. Treatment included injection of three lumbar trigger points.

On the follow up clinical note dated January 7, 2013 Dr. noted that despite conservative treatment including lumbar epidural steroid injections, pain persisted in the right leg and then developed in the left leg. Lumbar epidural steroid injections helped only a little. Physical examination revealed weakness of the extensor hallucis longus and also of the ankle dorsiflexors. Sensory exam revealed hypoesthesia over the lateral aspect of the right foot. Dr. reviewed findings on lumbar myelography from January 7, 2013. Post myelogram CT showed bilateral L5-S1 foraminal stenosis secondary to disc space narrowing with osteophyte lipping. There was diffuse L4-L5 disc protrusion extending into both neural foramina. The mid-sagittal spinal diameter was reduced to 9.5 millimeters. Dr. diagnosed right L5 radiculopathy with intermittent left sided symptoms. He suspected that the worker was likely symptomatic from the L4-5 level which had gotten worse compared to prior diagnostic studies. He suspected that the L5 radiculopathy also may be coming from right L5-S1 foraminal stenosis. He recommended a right L5-S1 selective nerve root block and mentioned an L4-5 selective nerve root block at another time. He also requested

an EMG of the lower extremities to see if there is any evidence of denervation or axonal loss.

On 2/21/13 the requested electromyography and nerve conduction studies were non-authorized. On 03/05/2013 Dr. appealed the decision, stating that [the worker]

- Had physical examination findings consistent with right L5 radiculopathy
- Had imaging studies that showed bilateral L5-S1 foraminal stenosis and L4-5 disc protrusion with a slightly greater component on the left, narrowing the right but also narrowing the right L4-5 lateral recess.
- Had intermittent left sided symptoms.

Dr. suspected that the worker was likely symptomatic from the L4-5 level but that the symptoms could be coming from the right L5-S1 foraminal stenosis. He requested electrophysiological studies to see if there is any evidence of denervation or axonal loss.

The non-authorization was upheld on reconsideration.

DIAGNOSTIC STUDIES

- 2010/03/16: lumbar spine x-rays: no acute abnormality. M.D.
- 2012/06/19: x-rays of the lumbar spine with additional flexion and extension views. Impression: postoperative changes. No evidence for abnormal motion.
- 2012/07/11: MRI lumbar spine without contrast.
- 2013/01/07: CT lumbar spine with myelogram. Impression: degenerative spondylosis within the lumbar spine predominantly at the levels of L4-L5 and L5-S1.
- 2013/01/07: lumbar myelogram. Reported by M.D.
    - At the L1/L2 level, the intravertebral disk has a normal appearance. At the L2/L3 level, the intravertebral disk has a normal appearance.
    - At the L3/L4 level, there is a minimal 1 to 2-mm disk bulge. There is no evidence for central canal stenosis. There is no evidence for neural foraminal stenosis.
    - At the L4/L5 level, there is a moderate 3 to 4 mm diffuse disk bulge. Slightly greater left paracentral component with moderate left lateral recess narrowing and mild to moderate right lateral recess narrowing. Contouring of the anterior thecal sac. AP canal diameter measures 10 mm- There is no evidence for neural foraminal stenosis. Mild
    - bilateral facet arthropathy and ligamentum flavum hypertrophy.
    - At the L5/S1 level, evidence of prior right hemilaminotomy and diskectomy. Small broad-based left paracentral disk protrusion with mild left lateral recess narrowing_ No evidence for spinal stenosis. Facet arthropathy extends into the neural foramen resulting in

moderate bilateral neural foraminal stenosis best appreciated on series 603 image number 25 and series 603 image number 40.

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

- On June 20, 2011 Dr. diagnosed right S1 radiculopathy per electrophysiological studies, right L5 to S1 radiculopathy by physical examination.
- The surgery performed June 21, 2012 was for treatment of right S1 radiculopathy.
- In the clinical records of January 2012 and March 5, 2013 Dr. documented clinical findings consistent with right L5 radiculopathy, with intermittent symptoms on the left.
- The Lumbar CT myelogram on 01/07/2013 reported bilateral L4-L5 lateral recess narrowing and bilateral L5-S1 neural foraminal stenosis.

The above-summarized clinical notes, physical examination findings and diagnostic imaging reports have been provided by competent, expert examiners. Together the above findings on the history, physical examination and imaging studies can be taken to support a diagnosis of old, chronic or recurrent right S1 and possibly L5 radiculopathy as well as left L5 and/or left S1 radiculopathy which may or may not be a new development. Hence, the requested electrodiagnostic studies should not be non-certified on the grounds that radiculopathy is already clinically obvious. Dr. requested electrophysiological studies to see if there is any evidence of denervation or axonal loss. Results of such studies could be compared with results of the previous tests done in February 2011 to help guide decisions about treatment. Furthermore, according to the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) additional testing is warranted for a clinical situation such as this.

From the Recommended Policy for Electrodiagnostic Medicine, The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following pertaining to the Frequency of Electrodiagnostic Testing in a Given Patient:
There are many clinical situations where good medical management requires repeat testing, such as in the following examples (original numbering is maintained):
1. Second diagnosis. Where a single diagnosis is made on the first visit, but the patient subsequently develops a new set of symptoms, further evaluation is required for a second diagnosis that treatment can begin.

3. Unexpected course or change in course of the disease. In certain situations, management of a diagnosed condition may not yield expected results or new, questionably related problems may occur …. In these instances, reexamination is appropriate.

Recommended Policy for Electrodiagnostic Medicine: American Association of Neuromuscular & Electrodiagnostic Medicine, American Academy of Neurology American Academy of Physical Medicine and Rehabilitation pertaining to electrodiagnostic evaluation of radiculopathy:
A minimal evaluation for radiculopathy includes 1 motor and 1 sensory NCS and a needle EMG examination of the involved limb. However, the EDX testing can include up to 3 motor NCSs (in cases of an abnormal motor NCS, the same nerve in the contralateral limb and another motor nerve in the ipsilateral limb can be studied) and 2 sensory NCSs. Bilateral studies are often necessary to exclude a central disc herniation with bilateral radiculopathies or spinal stenosis or to differentiate between radiculopathy and plexopathy, polyneuropathy, or mononeuropathy. H reflexes and F waves can provide useful complementary information that is helpful in the evaluation of suspected radiculopathy and can add to the certainty of electrodiagnostic information supporting a diagnosis of root dysfunction. Radiculopathies cannot be diagnosed by NCS alone; needle EMG must be performed to confirm a radiculopathy. Therefore, these studies should be performed together by 1 physician supervising and/or performing all aspects of the study

ODG –TWC Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 03/12/13): Electrodiagnostic studies (EDS)

Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. For more information and references, see the Carpal Tunnel Syndrome Chapter. Below are the Minimum Standards from that chapter.
Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards:

(1) EDX testing should be medically indicated (i.e., to rule out radiculopathy, lumbar plexopathy, peripheral neuropathy).
(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. If both tests are done, the reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression.
(7) If both tests are done, 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) Note: For low back NCS are not recommended and EMGs are recommended in some cases, so generally they would not both be covered in a report for a low back condition.

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.)

H-reflex tests
Recommended. See EMGs (electromyography).

Bigos SJ
Perils, pitfalls, and accomplishments of guidelines for treatment of back problems, Neurol Clin 1999 Feb;17(1):179-92, as cited in the ODG-TWC Guides pertaining to the Low Back

Summary of Findings and Recommendation Statements about Evidence with Amount of Evidence to Support the Statement (A, B, C, D), Detection of Physiologic Abnormalities (14 studies)

- Recommend: Needle EMG and H-reflex tests to clarify nerve root dysfunction (C).
- Recommend Against: EMG for clinically obvious radiculopathy (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)**
American Association of Neuromuscular & Electrodiagnostic Medicine,
American Academy of Neurology
American Academy of Physical Medicine and Rehabilitation

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**