CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: December 21, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
1 Electromyography/Nerve Conduction Velocity Study (EMG/NCS) of the Bilateral Lower Extremities between 11/27/2012 and 1/26/2013.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

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:
08/13/12: New Patient Evaluation
08/13/12: X-ray Lumbar Spine-5 views
08/16/12: Follow-up Evaluation
08/27/12: Follow-up Evaluation
09/04/12: Follow-up Evaluation
09/05/12: Physical Therapy Evaluation
09/07/12: Physical Therapy Daily Progress Note
09/12/12: Follow-up Evaluation
09/12/12: Physical Therapy Daily Progress Note
09/20/12: Follow-up Evaluation
10/04/12: Follow-up Evaluation
10/09/12: MRI Lumbar Spine w/o Contrast
10/11/12: Follow-up Evaluation

10/24/12: Peer Review
11/06/12: Evaluation
11/26/12: UR performed
12/03/12: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who was injured on xx/xx/xx.

On August 13, 2012, the claimant was evaluated for low back pain with radiation into the left leg. On physical examination there was loss of lumbosacral lordosis, tenderness of the paravertebral musculature and restricted range of motion of the lumbar spine. Patellar deep tendon reflexes were 0/2 on the right and 1/2 on the left. There were no sensory changes. Straight leg raise was negative, EHL test was negative and Patrick-Fabere test was negative. Diagnosis: Lumbar sprain/strain. Plan: Prescription for Hydrocodone, Cyclobenzaprine, and Ibuprofen. Physical therapy was recommended 3 times a week for 2 weeks and modified work.

On August 13, 2012, X-rays of the Lumbar Spine, Impression: No acute bony compression or fracture.

On August 27, 2012, the claimant was re-evaluated who reported continued low back pain and left buttock pain and numbness of the left anterior thigh. Hydrocodone was discontinued and he was given a prescription for Tramadol and Skelaxin. Physical therapy was still recommended.

On September 5, 2012, the claimant was evaluated for physical therapy. It was recommended he participate 3 times a week for 2 weeks.

On September 20, 2012, the claimant was re-evaluated who reported that following his appointment he had questions regarding his work restrictions regarding the removal of the restriction for driving heavy equipment, bending, twisting, pushing and pulling. He stated he had been offered light duty, but did not want to be assigned certain jobs as he didn't want to get worse. attempted to advise him to return sooner and that at 5 weeks out from his type of injury, he should be further along in his recovery and that he should be more active. It was reported that the claimant unhappy and wanted to see another doctor. stated that he observed the claimant to sit and stand without discomfort, to walk at a fairly rapid pace without difficulty and pull open the door to the waiting room and clinical without problems.

On October 9, 2012, MRI of the Lumbar Spine, Impression: 1. There is mild to moderate disk dehydration at L4-L5 and L5-S1 without significant loss of disk space height. There are midline disk protrusions at both levels. At the L4-L5 level, this extends slightly more to the left than right of midline. There is borderline central spinal stenosis and left greater than right subarticular recess stenosis here. Mild facet hypertrophy is present. At the L5-S1 level, there is annular fissuring centrally. There is no mass effect on nerve roots. Both disk

protrusions are 4-5 mm in AP extent. 2. The upper lumbar levels and conus are unremarkable.

On October 11, 2012, the claimant was re-evaluated who reported on physical examination tenderness of the paravertebral musculature, restricted ROM and positive Faber's test on the right.

On November 6, 2012, the claimant was evaluated for low back pain radiating to right lower extremity with left leg numbness noted. Current medications were listed as: Hydrocodone, Cyclobenzaprine HCL, and Ibuprofen 800 mg. On physical examination he was sitting comfortably. He did not have difficulty acquiring a full, upright position. His gait was balanced. Lower extremity strength was symmetrically present in all lower extremity muscle groups. Lower extremity reflexes were symmetrically present and normal. Light touch was normal for all lumbar dermatomes. Assessment: Lumbar radicular syndrome and Herniated disc L4-5, L5-S1. Plan: ESI lumbar, continue oral medications, continue work restrictions.

On November 26, 2012, performed a UR. Rationale for Denial: This is a request for EMG/NCS of the bilateral lower extremities. Objective clinical findings were normal and did not suggest radiculopathy to warrant further studies. Furthermore, the progress note also recommended ESI and hence, the necessity of the EMG/NCV is questionable. The rationale of the testing is not clearly stated and it also needs to be known if the findings of the test would impact the management. Hence, the medical necessity of the request has not been established.

On December 3, 2012, performed a UR. Rationale for Denial: No updated documentation was provided that addressed the aforementioned issues. The latest medical report dated 11/6/12 showed the patient having normal strength, normal sensation, and symmetric reflexes, which do not suggest any abnormality that would point to a nerve injury. As such, the previous non-certification is upheld.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse determinations are upheld. The most recent evaluation on November 6, 2012 revealed a normal neuro exam. reported lower extremity strength was symmetrically present in all lower extremity muscle groups and lower extremity reflexes were symmetrically present and normal. There was also no indication of how the results of the EMG/NCS would help in determining diagnosis or treatment recommendations. Therefore, the request for 1 Electromyography/Nerve Conduction Velocity Study (EMG/NCS) of the Bilateral Lower Extremities between 11/27/2012 and 1/26/2013 is not found to be medically necessary.

PER ODG:

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)**