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Notice of Independent Review Decision

DATE: September 9, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
EMG/NCV Bilateral Lower Extremities (99203 ov pur) 95911 95886

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is certified by the American Board of Orthopaedic Surgeons with 42 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:
07/06/11, 08/17/11, 09/14/11, 10/12/11: Office visit
08/02/11: Left Knee 2V report
08/02/11: Three-Phase Bone Scan Knees report
08/04/11: Stress Test
05/28/13: UR performed
07/25/13: UR performed
09/21/11: Preauthorization request
09/22/11: Peer to Peer Review notes
09/23/11: UR
09/28/11: Work Comp Preauthorization Request
10/03/11: Utilization review decision
10/05/11: Cardiology Clearance
10/11/11: Laboratory Report
10/14/11: Preop Orders
01/27/12: Surgery/Precert Notes
01/27/12: Work Comp Preauthorization Request Form
02/20/12: Preop Orders

02/22/12, 02/23/12: Laboratory Report
03/09/12: Admission Notification
03/09/12: Preop History and Physical
03/09/12: X-ray Left Knee report interpreted
03/10/12: Operative Report
03/10/12: X-ray Left Knee report
03/15/12: Discharge Note
03/20/12: Physical Therapy Visit Note
03/27/12: Surgical Pathology Report
03/28/12: Office visit
04/20/12: Physical Therapy Evaluation Summary
05/09/12: X-ray Left Knee report
05/09/12, 06/20/12, 08/29/12, 01/23/13, 05/08/13: Office Visit
08/28/12: Physical Therapy Discharge Summary
05/28/13: UR performed
07/25/13: UR performed
Treatment History from Insurance Company

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who injured his left knee when he fell while working on xx/xx/xx. He is status post multiple surgeries to the left knee, the most recent performed on March 10, 2012.

07/06/11: The claimant was evaluated for left knee pain. It was noted that he was status post knee replacements in 2000 and 2001.

08/02/11: X-ray left knee report interpreted. IMPRESSION: Total knee prosthesis in position as described. FINDINGS: The total knee prosthesis in anatomic alignment and position.

08/02/11: Three-Phase Bone Scan Knees report. IMPRESSION: No abnormal hyperemia of either knee is demonstrated. No abnormal soft tissue or early osseous uptake is identified. On delayed images, changes of previous left knee arthroplasty are apparent. There is a mild degree of increased uptake along the tibial plateau component of the arthroplasty, felt to be within expectation for previous arthroplasty. No additional increased uptake is seen on the delayed images. No abnormal uptake is seen along the femoral component.

03/10/12: Operative report. POSTOPERATIVE DIAGNOSIS: Soft tissue instability of the left knee with solid femoral and tibial component and lack of patella prosthesis. PROCEDURE: Two-part revision of tibial tray and addition of patellar prosthesis with soft tissue balancing.

03/09/12: X-ray Left Knee report interpreted. IMPRESSION: There is a total left knee arthroplasty. There is a clamp overlying the femoral shaft on the lateral projection. There is an opaque gauze overlying the proximal tibia. The deforming the soft tissues anterior and superior to the patella.

04/20/12: Physical Therapy Evaluation Summary. ASSESSMENT: Patient has good attitude and understanding. Skilled PT required to provide graded program to bring patient to higher functional level.

05/09/12: Left Knee Radiographs report. IMPRESSION: Postoperative changes with large osseous loose bodies in the posterior joint space. There are several tiny calcified or ossified densities in the anterior joint space as well as increased density in the infrapatellar fat, which could represent joint effusion/synovitis from the hardware.

01/23/13: The claimant was evaluated status post revision of left TKA with tibial tray and patella prosthesis. It was noted that he was overall doing better. His wound was well healed. He had more motion and stability than prior to surgery. He had been riding a bicycle. On gait testing, he had normal heel-toe ambulation. ROM 0-100 stable varus valgus. PLAN: Continue PT. Followup in 12 weeks.

05/08/13: The claimant was evaluated. He complained of pain in the mid calf that radiated to his toes, which started about one month prior. On exam, he has positive Tinel's at the lateral left calf. PLAN: EMG of the bilateral lower extremities to rule out nerve compression in the left calf.

05/28/13: UR performed. REVIEWER COMMENTS: The patient had multiple surgeries to the left knee with the most recent on 03/10/12 involving revision left total knee arthroplasty. Other treatments included medications, bracing, use of cane and crutches, chiropractic care, physical therapy, work hardening, HEP, and CPM. Records from 10/30/95 to 09/04/96 indicated mild loss off pinprick sensation along the left L3 dermatome with associated quadriceps weakness. However, electrodiagnostic testing of the lower extremities on 08/27/96 had been unremarkable. The patient was evaluated with imaging studies including triple phase bone scan on 08/02/11 showing mild uptake in the third phase along the tibial plateau surface of the arthroplasty felt to be within expectation for knee arthroplasty, and x-rays on 05/09/12 demonstrating postoperative changes with large osseous loose bodies in the posterior joint space and findings suggestive of effusion/synovitis from the hardware. As per 05/08/13 report, he was noted to have more motion and stability since the last surgery. He reported some pain in the mid calf that radiated to his toes. Examination revealed 0 to 100 degrees ROM, stable varus and valgus, and positive Tinel's at the lateral calf. EMG and NCV of the bilateral lower extremities were requested to assess for nerve compression in the left leg. Aside from positive Tinel's at the lateral calf, there was no documentation of motor-sensory findings that would warrant electrodiagnostic validation. Documentation of the patient's clinical course between 1996 and 2012 was not provided to determine what became of his previously noted left L3 neurologic impairment. The most recent reports did not reflect any current findings suggestive of radiculopathy that would justify EMG testing. His symptoms had been predominantly left-sided, and there was no documentation of right-sided findings that would warrant bilateral electrophysiologic evaluation. With the above issues, the medical necessity of this request is not fully substantiated.

07/25/13: UR performed. REVIEWER COMMENTS: The patient complains of pain in the left mid-calf area that radiates to his toes. Physical findings include a positive Tinel's in the lateral left calf. The request of an EMG/NCV for the bilateral lower extremities was previously denied due to lack of clinical findings to suggest radiculopathy in the bilateral lower extremities. Official Disability Guidelines recommend than an EMG/NCV would only be indicated after one month of conservative therapy. Clinical note dated 05/08/13 indicates that the radicular symptoms started the previous month. The clinical documentation submitted for review does not provide evidence of one month of conservative therapy. As such, the request is non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION: The previous adverse determinations are upheld. The ODG recommend that EMG be obtained only after one month of conservative therapy. In this case, the documentation submitted demonstrates a lack of conservative care and abnormal physical exam. Therefore, the claimant does not meet the Official Disability Guidelines. The request for EMG/NCV Bilateral Lower Extremities (99203 ov pur) 95911 95886 is not medically necessary.

ODG:

Electrodiagnostic testing (EMG/NCS)	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. **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. (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. (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)

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)**