



**Notice of Independent Review Decision - WC**

**DATE OF REVIEW:**

01/20/14

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

NCS Bilateral Lower Extremities  
EMG Bilateral Lower Extremities

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board Certified in Physical Medicine & 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

NCS Bilateral Lower Extremities – UPHELD  
EMG Bilateral Lower Extremities – UPHELD

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Lumbar Spine MRI, 04/01/13
- Office Visit, 04/11/13, 04/26/13, 05/22/13, 06/14/13, 07/11/13, 07/30/13, 10/29/13
- Operative Report, 04/16/13
- Authorization Request, 07/15/13, 08/27/13, 09/11/13, 11/05/13
- Outpatient Rehabilitation Evaluation Summary, 07/24/13
- Denial Letters, 11/08/13, 12/18/13

- Carrier Submission, 01/03/14, 01/09/14

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The records available for review indicate that on the date of injury the patient sustained a fall in the work place.

A lumbar MRI scan obtained on 04/01/13 revealed findings consistent with the presence of a disc bulge at the L1-L2, L2-L3, and L3-L4 levels. There was documentation of spinal stenosis at the L4-L5 level with moderate to severe left-sided foraminal narrowing and severe right-sided foraminal narrowing. There was evidence of a disc bulge at the L5-S1 level.

A medical document dated 04/11/13 indicated that subjectively there were symptoms of low back pain with radiation to the left lower extremity. On this date, the patient was evaluated. It was recommended that the patient receive access to treatment in the form of a lumbar epidural steroid injection (ESI).

A left L5 transforaminal ESI was provided to the patient on 04/16/13. This procedure was performed.

The patient was evaluated on 04/26/13. On this date, it was documented that there were symptoms of persistent low back pain with radiation to the left lower extremity. It was recommended that he undergo a repeat lumbar ESI in an effort to decrease pain symptoms.

On 05/22/13, the patient was re-evaluated. On this date, it was documented that he was on narcotic medication for management of pain symptoms.

evaluated the patient on 06/14/13. It was documented that authorization had not been given for him to undergo a repeat lumbar ESI.

On 07/11/13, the patient was evaluated. It was documented that the patient was with no improvement in pain symptoms. There were symptoms of low back pain with radiation to the left lower extremity. It was indicated that consideration could be given for lumbar spine surgery in an effort to decrease symptoms of low back pain.

The patient was evaluated on 07/30/13. It was documented that he was with symptoms of severe left-sided sciatica. It was documented that the history and examination were consistent with a left L5 radiculopathy. There was documentation of decreased sensation in the left L5 nerve root distribution, as well as documentation of decreased strength in the left extensor hallucis longus muscle and tibialis anterior muscle.

On 10/29/13, the patient received an assessment. It was recommended that he undergo an electrodiagnostic assessment. It was indicated that surgery could be considered to the lumbar spine in the form of a decompression at the L4-L5 level with a fusion, as well as a decompression at the L2-L3 level without a fusion.

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

Based upon the medical documentation currently available for review, medical necessity for an electrodiagnostic assessment is not established per criteria set forth by Official Disability Guidelines. This reference would not support this specific request to be one of medical necessity, as the records available for review indicate that there is documentation of a medical diagnosis of a lumbar radiculopathy referable to the left lower extremity, which, per review of the records, correlates with the documented lumbar MRI test results of 04/01/13. The records available for review indicate that the documented signs and symptoms, physical examination findings, and documented radiographic test results correlate. As a result, the above-noted reference would not support this request to be one of medical necessity, as there is no indication to justify how the results of the requested diagnostic study would affect the treatment plan. The above-noted reference does not provide data to support this specific request to be one of medical necessity for the described medical situation.

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

- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**