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Notice of Independent Review Decision

December 17, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

EMG/NCS study of the right lower extremity

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

Board Certified Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME:

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

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:

- Utilization reviews (09/26/13, 11/18/13)
- Procedures (06/24/10)
- Office visits (08/22/11 - 12/04/13)
- Diagnostics (01/13/03 - 10/17/13)
- Utilization reviews (09/26/13, 11/18/13)
- Diagnostics (10/17/13)
- Office visits (05/21/03 – 10/24/13)
- Diagnostics (07/17/03 –08/22/11)
- Procedures (07/17/03 – 06/24/10)

- Therapy (08/12/03 - 08/11/10)
- Utilization reviews (09/26/13, 11/18/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is male who sustained back injury on xx/xx/xx.

2003: On July 16, 2003, evaluated the patient for low back pain and right thigh pain. Examination showed symmetrically absent reflexes at the knees and ankles. The patient could do single leg squat, but subjectively stated that the right leg felt weaker. The TA strength was 4+/5. Diagnosis was low back and right leg pain with weakness of TA status post fusion L3 to L5 with severe spinal stenosis L2-L3 with degenerative spondylolisthesis and mild stenosis at L1-L2. explained the upcoming surgery in terms of the procedure, risks and complications. It was noted that the patient had failed extensive conservative treatment. recommended proceeding with the planned surgery. He gave a prescription for bone growth stimulator.

On July 17, 2003, performed bilateral subtotal L3 laminectomy, total L2 laminectomy and partial bilateral L1 laminectomy (decompression L1-L2 and L2-L3 levels), foraminotomies L2-L3, L3-L4, decompression at L2 and L3 nerve roots bilaterally; removal of pedicle screws at L3 and upper portion of rod, placement of pedicle screws at L2 and L3 utilizing Spinal Concepts rods and screws, preparation of local bone graft, right iliac crest aspiration x3 and fusion augmentation with Cerasorb. It was noted that the patient had previously undergone a decompression and fusion from L3 to L5 and was treated conservatively with medications and epidural steroid injections.

On August 6, 2003, noted that Neurontin had helped the anterior thigh pain that the patient was having on the right side. He did have thigh weakness with giving way. He had been using a cane on the left side. The patient stated that he was really not having any significant back pain or leg pain it was just primarily weakness that was bothering him presently. showed the proper way to use the cane on the right hand to support the right leg. X-rays revealed L2-L3 instrumentation to be intact. refilled Lortab, recommended continuing Neurontin and starting physical therapy (PT).

From October 12, 2003, through November 19, 2003, the patient attended multiple sessions of PT consisting of hot packs, electrical stimulation and therapeutic exercises.

On September 3, 2003, noted that the patient was doing well. The patient had noted decreasing weakness in his right thigh. recommended continuing therapy and use of brace.

On October 8, 2003, noted that the patient was not working and recommended continuing rehabilitation.

On November 6, 2003, performed a medical evaluation and assessed statutory maximum medical improvement (MMI) as of November 3, 2003, with 5% whole person impairment (WPI) rating.

On November 19, 2003, noted that the patient had a little bit of pain in the tailbone area where he was previously given an injection. He was attending therapy. X-rays showed continued consolidation of the posterior lateral fusion mass at the L3-L4 level. stated that there was no need to consider work hardening or work conditioning. He recommended completing the ongoing PT and undergoing functional capacity evaluation (FCE). The patient was given health club membership so that he could continue doing his exercise on his own.

On December 9, 2013, saw the patient as the patient wanted to go over the impairment rating (IR) that was performed on him. The patient was awarded a 5% IR and he was subsequently given a 10% IR by his insurance company. Once the insurance company got the results of examination, they reduced it to 5% and the patient wanted to know why. went over the DWC clarification report with the patient. The patient appeared to be satisfied with this IR. instructed the patient that if he had difficulty with this or would like a second opinion, he was welcome to dispute this and could be seen by a designated doctor.

On December 12, 2003, the patient underwent an FCE and demonstrated the ability to perform at a light-medium physical demand level (PDL). The evaluator recommended continuing home exercise program (HEP) for flexibility and stabilization. The patient would benefit from a health club membership to increase strength and endurance.

On December 30, 2003, noted that the patient was status post 360 fusion from L4-sacrum. The patient was doing quite well. He was currently on no medications. The patient's FCE showed a current level of light/medium, 40 pounds occasional. This was adequate for him to drive a truck without loading or unloading. The recommendation was for the patient to continue HEP for flexibility and stabilization and for a health club membership to increase strength and endurance. The patient was given a prescription for a health club membership. The patient was to continue to train with TRC under these current parameters. He could follow-up for his postsurgical care.

2004: On February 9, 2004, noted that the patient was having mild amount of low back pain. X-rays of the lumbar spine showed con stretch from two-to-five with 360 degree fusion performed at L3-L4 and L4-L5 and extension of hardware at L1 to L2 without interbody fusion between L2-L3. It looked like the patient was having some loss of lordosis about the lateral gutters. On the AP view, it showed bony fusion occurring and well maintenance of pedicle screws. recommended sending the patient back to his work situation as previously determined by Worker's Compensation.

On July 28, 2004, noted that the patient was doing very well. He was working full time. The patient could flex and extend without pain. X-rays revealed posterior

lateral fusion to be healing and remodeling nicely. There was no motion with flexion and extension. The patient was cautioned about bending at the waist. He was to continue work with permanent restrictions of lifting no more than 40 pounds. He was to do exercises. recommended follow-up in one year.

2005 – 2009: No records are available.

2010: On March 10, 2010, the patient was evaluated. The patient reported that his pain after the second surgery at the adjacent level of L2 or L3 improved until a month ago when he started having the back pain radiating into the right leg. The pain was associated with a burning sensation and some weakness in the right leg. The patient stated that he had seen another doctor who stated that it might be because he was having increased low back pain, he had a possible stroke and he also stated that he had lost 16 pounds in the last month. The patient reported that his pain was very severe and it prevented him from doing his daily activities. He was having problems with sleeping. recommended starting PT and anti-inflammatories along with a muscle relaxant. The patient was to follow-up in three-to-four weeks if there was any no improvement. X-rays of the lumbosacral area showed a solid fusion from L2 to L5 with some loss of the sagittal lordosis.

On March 31, 2010, noted that the patient had not started PT as it was denied by the Worker's Compensation, but later it was noted to be approved. The patient did have some back pain and a bit of numbness and pain in his right anterior thigh. The patient stated that even if he was standing or walking, he would start feeling a burning sensation and that his leg would give out and he would fall. The patient did undergo a vascular evaluation and it was believed that it was secondary to something going on in his lumbar spine. He was unable to take Mobic or Zanaflex as it was denied by the Worker's Compensation. Diagnosis was lower back pain with right anterior thigh pain causing him to fall. recommended continuing PT and provided some samples of Lyrica. He recommended ordering a computerized tomography (CT) myelogram of the lumbar spine, if the patient did not show any improvement.

In April, the patient attended several sessions of PT consisting of cold pack and electrical stimulation. The therapist recommended using a walker.

On April 13, 2010, noted that the patient still continued to fall secondary to the amount of pain in his legs and the numbness and tingling he had. At that point, the therapist believed that he had not benefitted from PT at all and actually it had produced increased pain for him. The patient continued to use Mobic and Zanaflex with some minimal benefit. Lyrica had not provided much relief to him. The patient had difficulty with walking any distance secondary to numbness and tingling in his leg and pain. The patient stated that he had fallen quite a few times secondary to that. He noted that he could sit and get some minimal relief. His patellar and Achilles reflexes were diminished. The patient had make/break weakness in his left quadriceps. recommended using hydrocodone and ordered a CT myelogram. The patient was provided a permanent handicap placard as well as prescription for a walker.

On April 30, 2010, a post-myelogram CT scan of the lumbar spine showed the following: (1) Severe central canal stenosis at L1-L2 related to a degenerative grade I spondylolisthesis of L1 on L2 with marked hypertrophic facet joint changes present bilaterally. Very small laminectomies performed at this level. Moderate severe bilateral neural foraminal narrowing. (2) Bilateral pedicle screws at L2 and L3. The right L3 screw was lateral to the right L3 pedicle. There was a grade I spondylolisthesis of L2 on L3. The facet joints were fused. Asymmetric extension of bone spurs noted into the far left lateral region. Laminectomies have been performed at this level. (3) Bilateral pedicle screws noted at L4 and L5. The left L5 pedicle screw might minimally breach the superior margin of the left L5-S1 neural foramen. Laminectomies performed at this level. (4) Solid interbody fusion at L3-L4 and L4-L5. There was solid intertransverse bone fusion present bilaterally from L3 to L5. There was a fused appearance of the facet joints bilaterally from L2-L3 through L4-L5. (5) Degenerative facet joint changes at L5-S1. There was decreased filling of the left S1 nerve root sleeve compared to the right of uncertain etiology. Mild right and moderate left neural foraminal narrowing noted at L5-S1. (6) Posterior spondylosis at T12-L1.

On May 3, 2010, reviewed the findings of the myelogram. The patient was noted to have significant stenosis at the L1-L2 level to the point of where a little contrast could even extend inferiorly. He did have a possible grade I spondylolisthesis of L1 on L2. assessed severe central canal stenosis at L1-L2 level with fusion from L2 to L5. Surgical intervention including a formal decompression with a possible in situ fusion was recommended.

On June 14, 2010, noted that the patient continued to have left buttock and posterior thigh pain and anterior thigh burning. recommended proceeding with a decompression at the L2-L3 level with possible in situ fusion.

On June 24, 2010, performed a revision decompression at L1-L2, decompression of the L2 nerve roots bilaterally with foraminotomy at L1-L2, repair of incidental durotomy, posterolateral fusion at L1-L2 utilizing local bone graft and preparation of the local bone graft.

On July 7, 2010, obtained x-rays of the lumbar spine which showed decompression at the L1-L2 level and the in situ fusion. He recommended physical therapy (PT).

From July 14, 2010, through August 11, 2010, the patient attended multiple sessions of PT consisting of therapeutic exercises.

On August 12, 2010, recommended discontinuing therapy as the patient seemed to get bad headaches and also some numbness throughout his left thigh, which seemed to be progressing down wanting it to give way. The patient was started on Lyrica and he was to taper off use of the brace by staying out of it for two hours a day the first week and increasing about two hours each additional week.

On August 13, 2010, the patient was discharged from therapy and was recommended to continue exercises at home.

On September 21, 2010, double the dose of Lyrica to see if it helped improve the patient's left thigh symptoms. The patient did have left leg numbness as well as some burning. recommended considering repeat myelogram CT scan if the patient continued to have problem.

On November 17, 2010, noted that the patient continued to have back and left radicular pain. He was not taking any pain medication. Lyrica made him sick and hence he stopped it. He was having difficulty falling asleep or staying asleep. prescribed Neurontin and recommended continuing HEP and continuing walking for exercises. The patient was to follow-up in three months.

2011: On February 15, 2011, noted that for the last couple of weeks the lower back had been bothering the patient. The Workers Compensation had denied a prescription for Lyrica or Neurontin as they stated that it was for epilepsy. X-rays of the lumbar spine showed internal fixation to be intact. recommended trial of Mobic and follow-up in six months.

On August 22, 2011, noted that the patient was doing reasonably well. He was still having some problems with his back. Diagnosis was status post decompression at L1-L2 on July 24, 2010, status post previous decompression and fusion from L2 to L5 with chronic strain syndrome. The patient was not working. X-rays showed L2-L3 level to be unremarkable, screws at right L3 level unchanged, intact previous anterior interbody fusion at L3-L4 and L4-L5 and no instability at the levels. recommended follow-up in one year for repeat x-rays.

2012: No records are available.

2013: On January 13, 2013, a post myelogram CT scan of the lumbar spine showed the following findings: (1) Evidence of a previous decompression procedure as well as an anterior and a posterolateral fusion at L3-L4 and L4-L5. Good positioning of the bona graft at these two levels. Good positioning of the posterior instrumentation. The facet joints of these two levels appeared to be fused. The central canal and the foramina at L3-L4 appeared adequate. The central canal and the right foramen at L4-L5 appeared adequate. The left foramen might be slightly narrowed at L4-L5. Correlate with clinical evidence for left L4 radiculopathy. (2) The major abnormality on this examination was at L2-L3 and at L1-L2. (3) At L2-L3, there was severe central canal stenosis due to anterolisthesis as well as a broad-based bulge and bilateral facet joint hypertrophy. Contrast material was nearly completely effaced from this level, suggesting that a high degree of central canal stenosis was present. The foramina at L2-L3 also appeared to be narrowed bilaterally. (4) At L1-L2, central canal stenosis was also evident. Although not as severe as at the L2-L3 level, it was considered to be significant. This was due to a combination of a broad-based bulge and bilateral facet joint hypertrophy. The L1-L2 foramina appeared narrowed bilaterally. (5) At T12-L1, the central canal and the foramina appeared

within a normal range. The conus terminated here and appeared normal. (6) At L5-S1, there was a tendency to pseudarthrosis formation especially on the right. The central canal appeared somewhat narrowed. In addition, the foramina appeared narrowed. The later should be correlated with clinical evidence for bilateral L5 radiculopathy.

On August 7, 2013, evaluated the patient back after not having been seen for a little more than two years. The patient reported that he was doing well until Sunday about two weeks ago, he really stood up from a table at dinner, had slid the chair with the back of his leg and felt a pop and then noticed pain radiating across the top of his thigh down his leg and with some numbness of the right half of his foot. He saw his family doctor who gave Neurontin which did not help. The patient was having some difficulty standing on the toes on the right. X-rays showed internal fixation from L4-L5 and then from L2-L3, an interbody fusion anteriorly at L3-L4 and L4-L5, a posterolateral fusion at L2-L3 level with the rods removed. There was a flat back deformity. Diagnoses were acute right-sided low back, right leg pain radiating in the L5 distribution with numbness for approximately two weeks, rule out possible herniated nucleus pulposus (HNP) or foraminal protrusion L5-S1 on the right; status post decompression L1-L2 (June 10, 2010), status post previous decompression, fusion at L2-L5. prescribed gabapentin, Medrol Dosepak, Prilosec and recommended obtaining an MRI if the patient showed in signs of improvement.

On August 21, 2013, noted that the patient was not doing better. He complained of right-sided low back, right anterior thigh and shin pain and numbness in the upper right foot. The sitting root test produced right anterior thigh pain. The reflexes at the knees and ankles were symmetrically absent. There was no weakness. suspected a disc herniation at L5-S1 level or severe foraminal stenosis causing compression of the right L5 nerve root. recommended continuing gabapentin and recommended an MRI of the lumbar spine.

On September 10, 2013, MRI of the lumbar spine showed the following findings: (1) Limited study related to artifact from the patient's hardware. (2) A 6 mm broad-based posterior disc protrusion at T12-L1 lateralizing to the right of midline with mild central canal narrowing suspected. (3) Moderate central canal stenosis suspected at the L1-L2 level related to a grade I spondylolisthesis of L1 on L2 with 5 mm broad-based posterior disc protrusion and a degenerative appearance of the facet joints. Severe right and moderate severe left neural foraminal narrowing was seen. (4) Severe right and mild left neural foraminal narrowing noted at the T12-L1 level.

On September 18, 2013, reviewed MRI of the lumbar spine which showed evidence of moderate stenosis L1 with a couple of millimeters of spondylolisthesis that appeared to be stable on previous flexion and extension. explained that because the artifact made it difficult to be actually certain of the pathology at that level of L1 to as well as assessing the L5-S1 level, he believed that the patient needed to undergo a lumbar myelogram CT as well as an electromyography/nerve conduction study (EMG/NCS).

Per utilization review dated September 26, 2013, the request for EMG/NCV study of the right lower extremity was denied with the following rationale: *“The Official Disability Guidelines indicate that electromyography may be useful to obtain unequivocal evidence of radiculopathy after a month of conservative therapy; however, EMGs are not necessary if radiculopathy is already clinically obvious. Furthermore, nerve conduction studies are not recommended as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The documentation submitted for review details on physical examination that the patient has evidence of paresthesia in an L5 distribution. Given the above, the request for EMG Right Lower Extremity - 95860, NCS Right Lower Extremity - 95904 is non-certified. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified.”*

On October 17, 2013, a post myelogram CT scan of the lumbar spine showed the following findings: (1) Moderate-to-severe central canal stenosis again noted at L1-L2 related to the grade I spondylolisthesis of the L1 on L2 with posterior bony spurs and some disc material indentified which was difficult to adequately quantify. Some calcification of the ligamentum flavum was also indentified. The AP diameter of the spinal canal appeared to be slightly more narrowed than was noted on the prior examination. (2) Interval development of central canal stenosis at the L5-S1 level with decreased amount of contrast present within the thecal sac at this level compared to the prior study. The findings were suspicious for a posterior central disc protrusion or extrusion although this was somewhat difficult to visualize related to artifact. There was non-filling of the S1 nerve root sleeve which was different than was noted on the prior examination. (3) Solid interbody fusion noted from L2-L5 with pedicle screws identified at those levels. There was mild fusion of the facet joints from L2-L5 bilaterally. Laminectomies beginning at the inferior most aspect of the L1-L2 disc space below the level of the stenosis and extending to L3. There were also laminectomies identified at L3-L4 with evidence of posterior lateral fusion. Laminectomies identified at L3-L4 with evidence of posterior lateral fusion. Laminectomies were also noted at L4-L5. (4) Mild central canal stenosis at T12-L1 related to 5-6 mm right paracentral osteophytes spurs identified as well as degenerative facet joint changes. Severe bilateral neural foraminal narrowing was seen. The central canal narrowing was slightly more prominent than noted on the prior study.

On October 22, 2013, reviewed the lumbar myelogram CT scan. The patient stated that the pain was more tolerable during the day once he would get up and move around. stated that with the flat back deformity from L2-L5 the patient's back was very complicated. It was a very complicated situation as well as having abnormalities at these levels above and below. recommended doubling the night dose of Neurontin since that seemed to bother him the most at night.

Per reconsideration review dated November 18, 2013; the request for EMG/NCV study of the right lower extremity was denied with the following rationale: *“The clinical information submitted for review fails to meet the evidence-based*

guidelines for the requested service. The mechanism of injury was not provided. The medications were not provided. The Official Disability Guidelines recommend an EMG to obtain unequivocal evidence of radiculopathy after one month of conservative therapy, but that an EMG is not necessary if radiculopathy is already clinically obvious and that nerve conduction studies are minimally justified when a patient is presumed to have symptoms on the basis of radiculopathy. The office note dated August 21, 2013, revealed that the patient had a sitting root test that produced anterior thigh pain, reflexes were absent in the knees and ankles and the patient was noted to have acute right-sided low back and right leg pain radiating in the L5 distribution with numbness since the end of July. The office note dated September 18, 2013, indicated that the patient had acute right-sided low back pain, right leg pain with groin pain radiating to the anterior thigh. The clinical documentation submitted for review indicated the patient had signs and symptoms of radiculopathy. Given the findings of radiculopathy upon examination, the EMG and the nerve conduction study are non-certified. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified.”

On December 4, 2013, noted that the patient was still having significant low back pain, in particular, the right groin and it seemed to bother him the most. The patient had pain into the groin. He would feel pain into the right groin area. X-rays of the pelvis did not show any significant narrowing of the hip joints on either side. recommended an EMG/NCS of the right lower extremity and a right L1-L2 transforaminal injection. The patient was to follow-up in two to three weeks.

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

Based on the medical records there is substantial evidence of a lumbar radiculopathy and is clearly not equivocal as required by ODG. Records indicate sitting root test that produced anterior thigh pain, reflexes were absent in the knees and ankles and the patient was noted to have acute right-sided low back and right leg pain radiating in the L5 distribution with numbness since the end of July. Per ODG “an EMG is not necessary if radiculopathy is already clinically obvious”, which in this case it is.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES