

Vanguard MedReview, Inc.

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Notice of Independent Review Decision

February 18, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

EMG/NCV BLE

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

This physician is Board Certified in Anesthesiology and has over 6 years of experience in Anesthesiology and Pain Management.

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:

09/21/2009: MRI of the Lumbar Spine without contrast
12/14/2011: Report of Medical Evaluation
10/18/2013: Follow-up Office Visit
12/17/2013: History and Physical
12/17/2013: Orders Note
12/18/2013: Peer Review
12/30/2013: UR performed
01/16/2014: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. he twisted and felt a sharp pain in his lower back. Treatment has consisted of medication, physical therapy, Chiropractic care, ESI times 2, lumbar laminectomy and partial facetectomy and neural foraminal decompression of the L5 root on February 27, 2010,

rehabilitative exercise program with work conditioning/work hardening, and a neural decompression and partial lumbar laminectomy on the L5-S1 space on February 28, 2010.

09/21/2009: MRI of the Lumbar Spine without contrast interpreted. **Impression:** 1 Broad-based right central/right subarticular disc herniation at L4-L5. Contact with the traversing right L5 nerve noted. 2. Right central disc herniation at L5-S1. Contact with the traversing right S1 nerve likely takes place.

12/14/2011: Report of Medical Evaluation. According to the report, an MRI was done on March 30, 2010 which showed a greater amount of disk bulge at the L5-S1 level on the right, greater amount than seen on the MRI or what is described on the MRI of September 21, 2009. Another MRI done on February 15, 2011 showed an increase of the size of the root compression on the right at the L5-S1 space.

10/18/2013: Follow-up Office Visit. Patient is still having back pain which spreads down his right leg. On physical examination he had a mild antalgic gait. Positive bilateral Straight Leg Raise at 45 degrees. 5+ strength, 2+ DTRs and no atrophy noted. Diagnosis: Chronic Low Back Pain. Plan: Refer to a spine orthopedic.

12/17/2013: History and Physical. Patient states that the pain is in the low back and radiates to the lateral aspect of the right leg to the calf with associated numbness/tingling in the foot. He states he occasionally has radiating pain into the left leg as well. He does complain of bilateral leg weakness, however the right is worse than the left. The patient states the pain is a 5/10. He describes it deep, constant, and burning. The pain is worsened with sitting, standing, walking, bending, cough/sneeze, and lying down. The pain is improved with nothing.

Physical Examination: The spinous process was tender to palpation at L4, L5, and S1. Right straight leg raise test was positive. There was pain with lumbar flexion. Strength was normal in the lower extremities. DTRS were equal and symmetrical throughout, knee reflex 2, and ankle reflex 2. **Assessment:** Back pain with radiation, Displacement of thoracic or lumbar intervertebral disc without myelopathy; lumbar intervertebral disc without myelopathy **Plan:** EMG/NCS to determine if there is truly a radicular component involved as his neurological exam is unremarkable. He will most likely need a lumbar transforaminal esi right L5, S1. In the meantime we will prescribe for him a compound cream as a topical analgesic. If he does not get relief from the injection we will consider a SCS as he has failed all other treatment methods including surgery.

12/30/2013: UR performed. Rational for Denial: Request is for EMG/NCS BLE. Based on the fact that the request includes NCV as part of evaluation of lumbar radiculopathy, according to ODG (low back) Treatment Guidelines, the request is not medically necessary. Would, however, approve BLE EMG only.

01/16/2014: UR performed. Rational for Denial: The documentation submitted for review elaborates the claimant complaining of low back pain despite 2 previous surgical interventions. Electrodiagnostic studies are recommended by the Official

Disability Guidelines provided the claimant meets specific criteria to include completion of 1 month course of conservative therapy. No information was submitted confirming the claimant's recent completion of any conservative treatments. Therefore, an EMG study would not be appropriate for this claimant at this time. The Official Disability Guidelines do not recommend the use of an NCV study on the basis of radiculopathy. The clinical notes indicate the claimant having specific complaints of numbness and tingling in the lower extremities. Given these findings, the request does not meet guideline recommendations.

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

The previous adverse determinations are upheld. The claimant continues to report back pain despite two previous surgical interventions. In order to justify electrodiagnostic studies, there must be demonstration of failed conservative therapy of at least one month. There was nothing submitted which would demonstrate that the claimant completed conservative therapy. Therefore, EMG would not be appropriate at this time. Additionally, NCV studies are not recommended by ODG on the basis of radiculopathy. Therefore, the request for EMG/NCV BLE is non-certified at this time.

Per ODG:

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| 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) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. (Al Nezari, 2013) In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. (Charles, 2013) 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)**