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Notice of Independent Review Decision

Case Number:

Date of Notice: 05/21/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

General Surgery

Description of the service or services in dispute:

EMG left lower extremity
NCV right lower extremity
EMG right lower extremity
NCV left lower extremity

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)

Patient Clinical History (Summary)

The patient is a male. On 12/13/14, an MRI of the lumbar spine revealed no central stenosis. Neural foraminal stenosis was seen in right L4-5 and left L5-S1 neural foramina. A cyst was filling the left L5-S1 neural foramen, which suggested a synovial cyst projecting anteriorly from the left L5-S1 facet joint which caused severe stenosis of the left L5-S1 neural foramen. There was 1mm disc bulges at L3-4 and L5-S1 abutting thecal sac and annular fissure was seen in the posterior annulus of the disc bulge at L5-S1. A 2mm disc bulge was seen at L4-5 flattening the thecal sac without causing central stenosis. Disc bulge and right facet joint hypertrophy caused mild stenosis of the right L4-5 neural foramen. On 01/12/15, a repeat MRI lumbar spine was considered normal with and without contrast. On 03/30/15, the patient was seen in clinic and was noted he was working when he slipped at the top step of a trailer that he was driving. He complained of left lower calf and leg pain rated 9/10. On exam, he had 4/5 strength diffusely from L2 to S1 on the left and strength on the right was preserved. Deep tendon reflexes were 0 at the knee and ankle. He had light touch sensation that was diminished in the S1 dermatome, at the site of the pain at the distal two thirds of left lower leg on the lateral side. Electrodiagnostic studies were recommended to evaluate for peripheral neuropathy as MRI without contrast and with contrast were contradictory and inconclusive. On 04/17/15, the patient returned to clinic, with complaints of left lower calf and leg pain, rated at 6/10. It was noted that an ultrasound to rule out DVT was negative. He again exhibited diffuse strength deficits from L2 to S1 on the left, and ankle and knee jerks were zero. He again had diminished sensation in S1 dermatome at the site of the pain at the distal two thirds of left lower leg on the lateral side. Electrodiagnostic studies were recommended.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 04/03/15, a utilization review report for the requested EMG/NCS to bilateral lower extremities utilized Official Disability Guideline, low back chapter and noted that EMG studies may be useful to obtain unequivocal evidence of radiculopathy after one month conservative care but is not medically necessary if radiculopathy is already clinically obvious. NCS is not recommended as there is minimal justification for NCS when the patient is presumed to have symptoms on the basis of radiculopathy. The records reviewed noted the patient had radiculopathy after conservative care had been documented, and thus an EMG would not be supported. It was noted that the provider indicated the request was made for left lower extremities to evaluate peripheral neuropathy due to conflicting reports from two separately read MRIs of the lumbar spine, and the request for NCS of bilateral lower extremities would be supported; however due to the jurisdiction of the case, Texas, the request could not be partially certified without peer to peer discussion and agreement and the request was non-certified in its entirety.

On 04/21/15, a utilization review for appeal for EMG/NCV to bilateral lower extremities utilized Official Disability Guidelines treatment index, low back chapter for electrodiagnostic studies noting EMGs are not medically necessary if radiculopathy is on the clinically obvious, and NCS are not recommended. The records reviewed noted the patient had documented pain radiating to his toes three through five on the left, indicative of radiculopathy, and the request was not supported as medically necessary.

The patient has diffuse lower extremities strength deficits rated 4/5 to the left lower extremity from L2 to S1. Deep tendon reflexes are zero at knees and ankles. The patient has diminished sensation to touch at the site of his pain, at the distal two thirds of the left lower leg on the lateral aspect. Previous exams for DVT were negative. A progress note dated 03/02/15 noted the patient had numbness in L5-S1 distribution to the left toes three through five and diminished sensation in S1 dermatome at the site of his pain. There is some discrepancy between the two closely dated MRIs. The 12/13/14 MRI lumbar spine revealed L1-2 and L2-3 showed no disc bulges, central or neural foraminal stenosis. There was a cyst filling the left L5-S1 neural foramen, suggestive of a synovial cyst, projecting anteriorly from the left L5-S1 facet joint that apparently caused severe stenosis on the left at L5-S1. There was also a disc bulge flattening the thecal sac L4-5 with facet joint hypertrophy in mild stenosis. However, on 01/12/15, repeat MRI lumbar spine documented that from L1-2 to L5-S1 the disc spaces normal without disc herniations or disc bulges or central canal stenosis or neural foraminal narrowing.

A review of the records indicate patient had past medical history only significant for hypertension since 2008 being placed on Lisinopril once daily. Therefore, there be no indication that the patient has diabetes to cause peripheral neuropathy. While the reports of the injury noted the patient slipped, there is no indication that he struck his left lower extremity at the time of his accident. Therefore, there is lack of clinical documentation supporting the patient has peripheral neuropathy caused by a comorbid disease and/or trauma to the left lower extremity. Radiculopathy has been documented by the physical examination. Official Disability Guidelines low back chapter indicates that EMG may be considered reasonable to attain unequivocal evidence of radiculopathy after one month conservative treatment but EMG is not necessary if radiculopathy is already clinically obvious. NCS are not recommended due to minimal justification for NCS when a patient is presumed to have symptoms on the basis of radiculopathy. Therefore it is the opinion of this reviewer that the request for EMG/NCV bilateral lower extremities is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPH- Agency for Healthcare Research and Quality Guidelines

- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment Guidelines
- Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)