

Independent Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: 817-274-0868

Fax: 817-549-0311

DATE OF REVIEW: March 18, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Electrodiagnostic Functional Assessment

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Subspecialty Board Certified in Electrodiagnostic Medicine

Residency Training PMR and ORTHOPAEDIC SURGERY

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Report 12/11/07 and 12/20/07

Letter 3/13/08

Medical Record of Dr. of Orthopedic Specialists 2/5/08

Designated Doctor Report Dr. 1/31/08

Xray Report Imaging 12/6/07

Medical Records Dr. 10/9/07, 11/15/07 and 1/4/08

Marketing Material re the EFA (No Date)

PATIENT CLINICAL HISTORY [SUMMARY]:

This man injured his back while lifting a 50 pound bag of chemicals. Dr. prescribed therapy for his L4-5 disc herniation and also advised physical therapy. The xray report (no MRI report) showed no abnormalities.

Dr. wrote that the man had an acute left sided L2.3.4 radiculopathy based upon electrodiagnostic findings. She expressed concern over unsuccessful epidural injections and failed response with facet medial nerve blocks. She cited an annular disc tear at L3-4 and a right paracentral L4-5 disc herniation on MRI. No MRI reports or emg reports were submitted. Dr. planned a TNS unit. She found the case manager wished for a Functional Electrodiagnostic Assessment.

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

Surface electromyography (SEMG)

Not recommended. Surface electromyography (SEMG), which records the summation of muscle activity from groups of muscles, a noninvasive procedure, is contrasted with needle electromyography, an invasive procedure, in which the electrical activity of individual muscles is recorded. Paraspinal SEMG, also referred to as paraspinal EMG scanning, has been explored as a technique to evaluate abnormal patterns of electrical activity in the paraspinal muscles in patients with back pain symptoms such as spasm, tenderness, limited range of motion, or postural disorders. Paraspinal SEMG is an office-based procedure that may be most commonly used by physiatrists or chiropractors. There are inadequate data regarding paraspinal SEMG to validate the three key attributes of any diagnostic test: its performance compared to a gold standard, how the test is used in the management of the patient, and validation that the changes in patient management result in an overall health benefit. Surface EMG and F-wave tests are not very specific and therefore are not recommended, but Needle EMG and H-reflex tests are recommended. ([Haig, 1996](#)) ([Greenough, 1998](#)) ([Roy, 1998](#)) ([Meyer, 1994](#)) ([BlueCross BlueShield, 2004](#)) ([CCGPP, 2005](#)) See [EMG's](#) (electromyography). SEMG may be of use in biofeedback training. See [Biofeedback](#).

The material provided shows that a large component of the EFA is its role as a form of a surface emg. The material supplied is largely marketing material that neither substantiates nor refutes the scientific value of this device. Statements are made about the device. Except for court cases, not of the statements of its validity are documented. There are many medical devices that are approved by the FDA that are not accepted as a current diagnostic or treatment protocol. This device or test apparently was requested by the case manager and the physical therapy. Apparently none of the physicians involved requested it. .

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)