

# Core 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Nov/30/2009

**IRO CASE #:**

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

EMG/NCV BLEs

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

MD, Board Certified in Physical Medicine and Rehabilitation  
Board Certified in Electrodiagnostic Medicine

**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**

Adverse Determinations, 9/30/09, 11/4/08

Dr. MD, 4/10/09

MRI of the Lumbar Spine, 4/27/09

MRI of the Thoracic Spine, 4/27/09

Progress Note, 4/27/09, 5/4/09, 5/18/09, 6/15/09, 6/22/09, 6/29/09, 8/14/09

Dr. MD, 7/7/09, 10/6/09

MD, 9/21/09, 10/19/09

ODG/TWC

**PATIENT CLINICAL HISTORY SUMMARY**

This is a female reportedly injured with a fall on xx/xx/xx. The medical records describe that she has low back pain sometimes going to the lower extremities. Dr. described local tenderness in the mid thoracic and lower lumbar region, positive SLR and some reduced strength. Dr. found local tenderness, no motor, sensory or reflex abnormalities. Dr. described local thoracic and lumbar tenderness with limited motion, positive SLR and no motor or sensory loss. There was no description of the pain in a radicular pattern. The MRI showed multilevel spondylosis with left moderate to severe foraminal narrowing at L5/S1 with mild stenosis. There was multilevel disc degeneration, herniation and stenosis in the thoracic spine noted in the medical records.

## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The records indicate the patient has spinal stenosis. There are complaints of back and lower extremity pain but not in a radicular pattern. There were no motor, sensory or reflex abnormalities described by the different doctors. The patient's MRIs showed degenerative changes and spinal stenosis. While the ODG does not support nerve conduction studies, H reflex abnormalities are of value for S1 radiculopathy, although they often duplicate the information obtained on needle electromyographic findings. Further, they can be abnormal when there is a diabetic neuropathy. EMGs can be used to establish the diagnosis of a radiculopathy when the diagnosis of a radiculopathy is not clinically obvious as is the case with this patient. Records indicate that spinal stenosis may be contributing to her back pain, but is not clearly the cause of the lower extremity symptoms. The reviewer finds that electrodiagnostic studies of the lower extremities are appropriate to confirm the presence of a radiculopathy and are in keeping with the ODG. While this may not alter treatment of her spinal stenosis, it may effect the impairment rating by confirming the lumbar radiculopathy. The reviewer finds that the request meets the ODG criteria. The reviewer finds that medical necessity exists for EMG/NCV BLEs.

### Electrodiagnostic studies (EDS)

See also Nerve conduction studies (NCS) and EMGs (EMG). For more information and references, see the Carpal Tunnel Syndrome Chapter. Below are the Minimum Standards from that chapter

Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards

- (1) EDX testing should be medically indicated.
- (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable.
- (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis.
- (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed.
- (5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted.
- (6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression.
- (7) In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009)

## 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) 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.

## 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.)

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

ACOEM-AMERICA 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)