

# US Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/27/2010

**IRO CASE #:**

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

Repeat EMG of the Lumbar spine

**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**

Official Disability Guidelines

11/11/10, 12/1/10

Wellness 11/22/10, 11/8/10

M.D. prescription for EMG 11/4/10

Imaging prescription for MRI 11/4/10

Letter Translated for Dr., 12/12/10

11/22/10

Physical and Occupational Therapy Notes, 11/9/10

EMG Report (in Spanish), Data in English, 10/23/10

DO, EMG, 2/6/09

MRI Report, 9/24/10, 7/23/09, 11/6/08

Spine Pain Solutions, 12/19/08

Hospital 9/29/08

**PATIENT CLINICAL HISTORY SUMMARY**

This is a man injured on xx/xx/xx. He reportedly had no improvement following back surgery and a repeat MRI and EMG in Mexico were abnormal. He has progressively worsening pain. Mr. noted that the patient is losing feeling. There is no history or physical provided beyond one by Dr. electrodiagnostic study of 2/6/09. He had leg pain more on the left than the right side. Dr. felt the studies showed a chronic bilateral L4 radiculopathy based upon the polyphasic potentials. There was slowing of the left sural nerve. An MRI from 7/23/09 showed "mild" "evidence of disc disease at L4-L5 and L5-S1" and spondylosis at L4/5. Another MRI was reportedly done in in 9/10. It reportedly showed per Mr. protrusions at the level of the prior surgery, "mild" "evidence of disc disease at L4-L5 and L5-S1" and spondylosis at L4/5.

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

There is no medical history provided. The closest thing is the 2009 report by Dr.. I could not determine what surgery was performed or when it was performed. There is no physical examination. As noted in the ODG this requested testing is not indicated if the presence of a radiculopathy is obvious. This requires a history and physical. Without any, I cannot support the medical necessity of the test. Further, the EMG report provided did show an L4/5 radiculopathy on the left. Without the exams beyond Mr. request for studies, I saw nothing to suggest that this needed to be repeated. The reviewer finds that there is no medical necessity for Repeat EMG of the Lumbar spine.

### Electrodiagnostic studies (EDS)

See also [Nerve conduction studies](#) (NCS) and [EMGs](#) (EMG). Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. 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](#))

### 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](#)) 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-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)