



**MEDICAL EVALUATORS
OF TEXAS** ASO, L.L.C.

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Notice of Independent Review Decision

DATE OF REVIEW: February 04, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV lower extremities

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

This case was reviewed by a physician board certified in Physical Medicine and Rehabilitation. The reviewer is currently licensed and practicing in the State of Texas.

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

Type of Document Received	Date(s) of Record
X-rays of the lumbar spine	10/14/2013
Office visits	10/21/2013 and 11/20/2013
MRI of the lumbar spine	11/19/2013
An initial adverse determination letter	12/05/2013
A request for reconsideration	12/20/2013
A second adverse determination letter	01/13/2014
A request for an IRO for the denied services of, "EMG/NCV"	01/22/2014

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a male who injured his lower back on xx/xx/xx. He reported he felt a pop in his hip and back and felt a sharp pain in his lower back. He had lumbar radiographs on



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10/14/2013 that showed lumbar spondylosis. He was seen on 10/21/2013 with chief complaint of constant lower back pain described as excruciating, shooting, sharp and stabbing. On physical exam, lumbar ROM was decreased with flexion, extension, and right and left lateral flexion. On lower extremity muscle testing, the strength was 4/5 in right lower extremity and 3/5 in left lower extremity. There was severe pain at L1-L5 and ilium bilaterally on palpation of spinal tissues. There was mild degree of swelling at L1-L5 and ilium bilaterally. There was moderate degree of hypertonicity of the lumbar paraspinal muscles bilaterally. There was severe tenderness at L5. Deep tendon reflexes were 3/5 patellar and Achilles bilaterally and 2/5 brachioradialis bilaterally. On orthopedic testing, Kemps Standing Test and SLR Test was positive bilaterally. Heel/toe walk was positive on the left. He was diagnosed with displacement of Lumbar IVD without myelopathy, neuralgia/radiculitis, and lumbar sprain. recommended physical therapy to reduce pain and inflammation and improve ROM, referral to orthopedic specialist, lumbar MRI, and FCE.

A MRI of the lumbar spine performed on 11/19/2013 showed multilevel degenerative changes, facet hypertrophy, spondylolisthesis at L5-S1, full thickness annular tear at L5-S1, and disc protrusion at L4-5 and L5-S1. He was seen for a follow up evaluation on 11/20/2013, physical exam showed moderate tightness of the lumbar paraspinal muscles bilaterally, intense pain at L1-L5 and ilium bilaterally on palpation, mild swelling at L1-L5 and ilium bilaterally. On trunk exam, there was tenderness at L5, moderate muscular hypertonicity of the soft tissues, and mild swelling at the lumbar spine. Mr. reported therapies were helping with reduced symptoms and lesser pain, more flexibility (ROM, and better sleeping at night. recommended referral to orthopedic surgeon; pain management specialist, , for possible ESI, and EMG study of lower extremities.

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

Based on the documented history, the claimant did not report lower extremity radicular type symptoms. However, on exam he did have bilateral leg weakness with bilateral SLR (which is indicative of S1 radicular symptomatology). Physical therapy was noted to help reduce pain symptoms and flexibility. Also, the initial plan is unclear as both surgery and pain management have been consulted.

As per ODG criteria for EMG, “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).” The ODG criteria for 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



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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.”

Based on history, physical exam, and lumbar MRI, there is a clinical documentation of radiculopathy and EMG likely would play no role in the treatment algorithm unless requested directly by treating surgeon. Therefore, at this time, based on ODG criteria, EMG is not recommended and medically necessary.

ODG Low back Chapter Criteria for 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.)

ODG Low Back Chapter Criteria for 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.



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**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)