

# Applied Assessments LLC

An Independent Review Organization

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## Notice of Independent Review Decision

Case Number:

Date of Notice: 10/07/2015

### Review Outcome:

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

Physical Medicine and Rehabilitation

### Description of the service or services in dispute:

EMG BUE/BLE

**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 xxxxxx, an MRI of the lumbar spine revealed spondylosis with a disc bulge at L3-4, resulting in mild bilateral subarticular recess narrowing. There was also spondylosis with a disc bulge at L4-5, resulting in moderate bilateral subarticular recess narrowing. Disc space narrowing, spondylosis and lateral disc bulging was seen at L5-S1, resulting in bilateral foraminal stenosis right worse than left. It was noted there was potential for impingement of the exiting L5 nerve roots. On 07/31/15, the patient was seen in clinic. They had complaints of low back pain. Objectively, lower extremity strength was rated at 5/5 throughout and there were no sensory deficits and reflexes were stated to be normal. On 09/02/15, the patient returned. It was noted the MRI of the lumbar spine had been reviewed. Objectively, he was alert and oriented x 3.

### support the decision.

On 08/14/15, a utilization review determination letter was submitted for the requested EMG for the bilateral upper and bilateral lower extremities, and it was noted that electrodiagnostic studies are recommended where a CT or MRI is equivocal and there are ongoing pain complaints that raise questions about whether they may be a neurological compromise that may be identifiable and the patient had back and bilateral lower extremity symptoms but there is no indication the patient had upper extremity complaints. No clear rationale for the request for bilateral upper extremity EMGs has been documented and the request was non-certified. On 09/03/15, an adverse determination for the requested EMG for the bilateral upper and bilateral lower extremities, was submitted, and it was noted there was no clinical evidence to support the patient's responsiveness to treatment for the upper extremities, and the patient did not have neurological defects to support radiculopathy findings to warrant an EMG for the upper extremities. It was further noted that the request for an EMG for the bilateral lower extremities was not entirely supported, as the patient had subjective radicular pain and subjective neurological sensation that correlated to having radiculopathy with an official MRI with clinical findings. Therefore the request was non-certified.

The submitted records indicate the patient has low back pain, and there is no indication for documenting the patient had radiculopathy or a question of radiculopathy to the upper extremities. There is no indication

for a need for EMG to the bilateral upper extremities. For the bilateral lower extremities, the guidelines state that EMG is recommended to obtain unequivocal evidence of radiculopathy after 1 month of conservative therapy but EMGs are not necessary if radiculopathy is already clinically obvious. Therefore it is the opinion of this reviewer that the request for an EMG to the bilateral upper extremities and 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 AHCPR-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)