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[Date notice sent to all parties]:

1/22/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: EP CNTY EMG and nerve conduction appeal.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified PM&R, Board Certified Pain Medicine**

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is an individual. On XX/XX/XX, an MRI of the lumbar spine revealed mild degenerative disc changes at L4-5 and L5-S1, with associated posterior annular fissure seen at both levels. There was a shallow posterior disc protrusion seen at L3-4 and L5-S1 levels, without significant compression of the nerve root. There was no significant neuroforaminal stenosis and the central canal was patent. On XX/XX/XX, the patient was seen in clinic. She had complaints of severe pain to the lumbar spine with radiation to her right leg. Physical examination found a positive straight leg raise for low back and lower extremity pain and reflexes were normal with the exception of the bilateral Achilles rated at 0/4 and motor strength was 5/5 throughout. She was given Gabapentin.

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

On XX/XX/XX, a preauthorization report and notification was submitted for the requested EMG and nerve conduction study. It was noted that guidelines state this type of study may be necessary when there is a need to develop unequivocal evidence of radiculopathy. There is no clinical indication of a verifiable radiculopathy or nerve root compromise, and therefore the request was non-certified. On XX/XX/XX, a preauthorization report and notification for the requested EMG and nerve conduction study, on appeal, noted the clinical assessment was benign low back pain without sciatica, and there is no notation of a verifiable radiculopathy diagnosis. The MRI was clear that there is no disc lesion compromising the nerve root and there is evidence of degenerative disc disease. Therefore the request was non-certified as there was no specific pathology suggestive of a nerve root compromise. The physical examination also found the patient to be 5/5 in strength, without sensory loss.

The guidelines state 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. NCV studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy.

On XX/XX/XX, an MRI of the lumbar spine revealed mild degenerative disc changes at L4-5 and L5-S1, with associated posterior annular fissure seen at both levels. There was a shallow posterior disc protrusion seen at L3-4 and L5-S1 levels, without significant compression of the nerve root. There was no significant neuroforaminal stenosis and the central canal was patent. On XX/XX/XX, the patient was seen in clinic. She had complaints of severe pain to the lumbar spine with radiation to her right leg. Physical examination found a positive straight leg raise for low back and lower extremity pain and reflexes were normal with the exception of the bilateral Achilles rated at 0/4 and motor strength was 5/5 throughout. She was given Gabapentin. The records do not document a need for obtaining unequivocal evidence of radiculopathy.

It is the opinion of this reviewer that the request for an EMG and nerve conduction study on appeal is not medically necessary and the prior denials are upheld.

IRO REVIEWER REPORT TEMPLATE -WC

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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) 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