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[Date notice sent to all parties]:

04/22/2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: EMG Test

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

Orthopaedic Surgery; XX Surgery

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]:

This case involves a now XX-year-old XX with a history of an occupational claim from XX. The mechanism of injury is detailed as XX a XX on a XX XX XX when XX was on the XX and a XX of XX from the XX. The patient immediately XX XX and XX to the XX. The MRI of the XX XX dated XX indicated the patient had XX XX XX at XX-XX and XX-XX measuring XX mm and XX-XX and XX-XX measuring XX mm. The XX XX was normal in signal. The office visit dated XX indicated the patient had pain in the XX XX. The pain was moderate and was rated 7/10. XX therapy helped a little bit. The patient had symptoms of weakness. The patient had pain radiating down the XX XX with occasional radiation of pain down the XX XX into the XX and XX, mostly at night. The patient reported XX/joint pain and XX pain. The patient reported numbness, dizziness and frequent or severe XX. The XX

examination revealed the patient had decreased range of motion of the XX XX and immense pain with XX rotation. The motor strength was rated 5/5. The diagnoses include XX pain and XX XX. The request was made for nerve conduction study/EMG of the XX XX. The physician further stated that it was opined the patient would benefit from XX epidural steroid injection for the treatment of XX XX, considering a failure to benefit from non-operative treatment.

The requested service was previously denied as there was a lack of documentation indicating the patient had complaints of any XX problems in the XX XX and there were no abnormal XX findings in the XX XX on XX examination.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The Official Disability Guidelines indicate that electromyography is recommended as an option in select cases. A positive diagnosis of XX requires the identification of XX abnormalities in XX or more muscles that share the same nerve root innervation but different in their XX nerve supply. EMG findings may not be predictive of surgical outcome in XX surgery, and patients may still benefit from surgery even in the absence of EMG findings of nerve root XX. XX electrodiagnostic studies are not necessary to demonstrate XX XX, but they have been suggested to confirm a XX XX abnormality or some problem other than XX radiculopathy, but these studies can result in unnecessary overtreatment. The patient had subjective complaints of weakness with pain radiating down the XX XX with occasional radiation of pain down the XX XX and XX and XX, mostly at XX. However, the patient did not complain of XX type symptoms. There were no objective findings on XX examination supportive of possible neuropathy and the need for an EMG per guideline recommendations. As such, the prior determination has been upheld. The EMG is not medically necessary.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES 17th Edition (web), 2019, XX & Upper XX Chapter, Electromyography (EMG)**