PHP_2.01.35	Paraspinal Surface Electromyography to Evaluate and Monitor Back Pain		
Original Policy Date:	December 1, 2025	**Effective Date:**	June 1, 2026
Section:	2.0 Medicine	**Page:**	Page 1 of 12

State Guidelines

Applicable Medi-Cal guidelines as of the publication of this policy (this guideline supersedes the criteria in the Policy Statement section below):

I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline:
- N/A

II. Department of Health Care Services (DHCS) Provider Manual Guideline:
- Medicine: Neurology and Neuromuscular (medne neu)
- TAR and Non-Standard Benefits List: Codes 90000 thru 99999 (tar and non cd9)
- TAR and Non-Standard Benefits List: Codes R0000 thru S9999 (tar and non cdrs)

The codes listed on the policy are included in the above Provider Manuals; however, there are no specific clinical guidelines.

III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline:
- N/A

NOTE: Refer to Appendix A to see the state guidelines/policy statement changes (if any) from the previous version.

Policy Statement

Any criteria that are not specifically addressed in the above Provider Manuals, please refer to the criteria below.

I. Paraspinal surface electromyography (SEMG) is considered **investigational** as a technique to diagnose or monitor back pain.

Policy Guidelines

Coding
See the Codes table for details.

Description

A noninvasive procedure that records the summation of muscle electrical activity, paraspinal surface electromyography (SEMG) has been investigated as a technique to evaluate the physiologic functioning of the back. Additionally, this procedure has been studied as a technique to evaluate abnormal patterns of electrical activity in the paraspinal muscles in individuals with back pain symptoms, such as spasm, tenderness, limited range of motion, or postural disorders.

Summary of Evidence

For individuals who have back pain who receive paraspinal surface electromyography (SEMG) for evaluation and monitoring, the evidence includes several nonrandomized studies on using findings to classify back pain. Relevant outcomes are test accuracy and validity, symptoms, functional outcomes, quality of life, and resource utilization. There have been no studies directly comparing SEMG with other noninvasive techniques for evaluating back pain, and standard criteria for normal and abnormal SEMG measurements have not been determined. Surface electromyography has been proposed as a noninvasive technique providing objective measurements that would inform treatment decisions in patients with back pain. While studies have shown that SEMG results have detected different pathologies in patients with back pain, none of the studies reported health outcomes. There are also no data on the impact of SEMG for managing back pain. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Additional Information

Not applicable.

Related Policies

- N/A

Benefit Application

Blue Shield of California Promise Health Plan is contracted with L.A. Care Health Plan for Los Angeles County and the Department of Health Care Services for San Diego County to provide Medi-Cal health benefits to its Medi-Cal recipients. In order to provide the best health care services and practices, Blue Shield of California Promise Health Plan has an extensive network of Medi-Cal primary care providers and specialists. Recognizing the rich diversity of its membership, our providers are given training and educational materials to assist in understanding the health needs of their patients as it could be affected by a member's cultural heritage.

The benefit designs associated with the Blue Shield of California Promise Medi-Cal plans are described in the Member Handbook (also called Evidence of Coverage).

Regulatory Status

Surface electromyography devices approved by the U.S. Food and Drug Administration (FDA) include those that use a single electrode or a fixed array of multiple surface electrodes. Examples include the CMAP Pro (Medical Technologies) and Model 9200 EMG System (Myotronics-Noromed).

Several FDA approved devices combine SEMG along the spine with other types of monitors. For example, in 2007, the Insight Discovery (Fasstech) was cleared for marketing through the 510(k) process. The device contains 6 sensor types, 1 of which is for SEMG. The indications include measuring bilateral differences in SEMG along the spine and measuring SEMG along the spine during functional tasks. (Earlier Insight models had fewer sensors.) FDA product code: IKN.

Health Equity Statement

Blue Shield of California Promise Health Plan's mission is to transform its health care delivery system into one that is worthy of families and friends. Blue Shield of California Promise Health Plan seeks to advance health equity in support of achieving Blue Shield of California Promise Health Plan's mission.

Blue Shield of California Promise Health Plan ensures all Covered Services are available and

accessible to all members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

Rationale

Background

Back Pain

Back pain is a common condition that affects most individuals at some point in their lives.[1] Identifying the pathogenesis of back pain is challenging, in part due to the complex anatomy of the back, which includes vertebrae, intervertebral discs, facet joints, spinal nerve roots, and numerous muscles. Back pain may be related to osteoarthritis, disc disease, subluxation, or muscular pathologies, such as muscle strain or spasm. Moreover, due to referred pain patterns, the location of the pain may not be anatomically related to the pathogenesis of the pain. For example, buttock or leg pain may be related to pathology in the spine. In addition to the diagnostic challenges of back pain is the natural history of acute back pain.

Diagnosis

Aside from physical examination, diagnostic testing includes imaging technologies, such as magnetic resonance imaging, designed to identify pathology (e.g., bulging discs), or tests such as discography to localize the abnormality by reproducing the pain syndrome.[1] However, these tests lack specificity and must be carefully interpreted in the context of the clinical picture. For example, magnetic resonance imaging identifies 5% of asymptomatic patients as having bulging discs. However, the presence of a bulging disc may only be clinically significant if correlated with other symptoms. Assessment of the musculature may focus on a range of motion or strength exercises.

In contrast to anatomic imaging, surface electromyography (SEMG), which records the summation of muscle activity from groups of muscles, has been investigated as a technique to evaluate the physiologic functioning of the back.[2] A noninvasive procedure, SEMG differs from needle electromyography, an invasive procedure in which the electrical activity of individual muscles is recorded. Paraspinal SEMG has been explored to evaluate abnormal patterns of electrical activity in the paraspinal muscles in patients with back pain symptoms such as spasm, tenderness, limited range of motion, or postural disorders. The technique is performed using a single or an array of electrodes placed on the skin surface, with recordings made at rest, in various positions, or after a series of exercises. Recordings can also be made by using a handheld device, which is applied to the skin at different sites. Electrical activity is assessed by computer analysis of the frequency spectrum (i.e., spectral analysis), amplitude, or root mean square of the electrical action potentials. In particular, a spectral analysis that focuses on the median frequency has been used to assess paraspinal muscle fatigue during isometric endurance exercises. Paraspinal SEMG has been researched as a technique to establish the etiology of back pain and has been used to monitor the response to therapy and establish physical activity limits, such as assessing capacity to lift heavy objects or ability to return to work.

Paraspinal SEMG is an office-based procedure. The following clinical applications of the paraspinal SEMG have been proposed:

- clarification of diagnosis (i.e., muscle, joint, or disc disease)
- selection of a course of medical therapy
- selection of a type of physical therapy
- preoperative evaluation
- postoperative rehabilitation
- follow-up of acute low back pain (LBP)

- evaluation of exacerbation of chronic LBP
- evaluation of pain management treatment techniques.

Treatment

Most cases of acute LBP resolve with conservative therapy (e.g., physical therapy) while continuing normal activities within limits permitted by the pain.[1] Therefore, initial imaging or other diagnostic testing is generally not recommended unless "red flag" warning signs are present or the pain persists for more than 4 to 6 weeks. Red flag findings include significant trauma, history of cancer, unrelenting night pain, fevers or chills, and progressive motor or sensory deficits.

Literature Review

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

Surface Electromyography

Paraspinal surface electromyography (SEMG) has been used as a research tool to evaluate the performance of paraspinal muscles in patients with back pain and to further understand the etiology of low back pain (LBP).[3,4,5,6] Preliminary research has also been performed to determine which SEMG parameters best differentiate patients with and without back pain.[7,8]

Clinical Context and Test Purpose

The purpose of paraspinal SEMG in individuals who have back pain is to identify the pathogenesis of the pain (i.e., muscle, joint, or disc disease) to inform a decision on a treatment plan.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with back pain.

Interventions

Paraspinal SEMG is a noninvasive technique that aggregates data on muscle activity from groups of muscles. One or more electrodes are placed on the skin surface, and recordings are taken at rest, in various positions, or during a series of exercises.

Comparators

Other noninvasive techniques to assess back pain include clinical examination and imaging technologies.

Outcomes

The general outcomes of interest are a reduction in back pain and improvement in activities of daily living.

Both false-positive test results and false-negative results can lead to an incorrect recommendation for the type of treatment or no treatment at all. Some treatments are long-term programs, and if individuals are incorrectly referred to the program, more appropriate therapy will be delayed.

Study Selection Criteria

For the evaluation of clinical validity of the paraspinal SEMG test, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores);
- Included a suitable reference standard;
- Patient/sample clinical characteristics were described;
- Patient/sample selection criteria were described.

Clinically Valid

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Review of Evidence

No articles that directly compare the results of SEMG (which tests groups of muscles) with needle electromyography (which tests individual muscles) for diagnosing any specific muscle pathology were identified in literature searches. However, the pathology of individual muscles (i.e., radiculopathy, neuropathy) may represent a different process than the pathology of muscle groups (i.e., muscle strain, spasm), and thus SEMG may be considered by its advocates as a unique test for which there is currently no criterion standard. Nevertheless, even if one accepts this premise, there are inadequate data to evaluate the diagnostic performance of SEMG. In some instances, the asymmetrical electrical activity may have been used to define abnormality; results may be compared with normative data. However, no published literature was identified defining what degree of asymmetry would constitute abnormality.

A study by du Rose and Breen (2016) looked into the relationship between lumbar intervertebral range of motion and paraspinal muscle activity in healthy adults, as measured by SEMG and quantitative fluoroscopy, to establish "normal" measurements. Fluoroscopic images and SEMG measurements were taken for 20 men with no history of LBP. What would be considered normal intervertebral ranges of motion were related to a diverse set of muscle activation patterns as measured by SEMG. The authors concluded that larger sample sizes and measurements from patients with LBP would be needed to established standard criterion.

Absent a criterion standard diagnostic test, correlation with the clinical symptoms and physical exam is critical. De Luca (1993) published a series of studies investigating a type of SEMG called the Back Analysis System, consisting of surface electrodes and other components to measure the electrical activity of muscles during isometric exercises designed to produce muscle fatigue.[4] Using physical exam and clinical history as a criterion standard, De Luca (1993) found that the Back Analysis System accurately identified control and back pain patients 84% and 91% of the time, respectively, with the values increasing to 100% in some populations. Accuracy was defined as the sum of true-positive and true-negative results. However, these studies were not designed as a clinical diagnostic tool per se but were intended to investigate the etiology of back pain and to investigate muscular fatigue patterns in patients with and without back pain.

Hu et al (2010, 2014) published 2 articles on dynamic topography, an approach to analyzing SEMG findings.[10,11] Both studies included patients with LBP and healthy controls. All participants underwent SEMG at study enrollment and then back pain patients participated in a rehabilitation program. The first study found different dynamic topography at baseline between the healthy people and back pain samples (a more symmetric pattern in healthy controls).[10] After physical therapy, the dynamic topography images of back pain patients were more similar to the healthy controls on some of the parameters assessed. In the second study, following rehabilitation, back pain patients were classified as responders or nonresponders based on changes in back pain severity.[11] Some associations were found between baseline SEMG parameters and response to rehabilitation. Surface

electromyography was not repeated after the rehabilitation program, and thus it is unclear whether there are any significant associations between continued symptoms and SEMG abnormalities. Moreover, it is unclear how SEMG analysis would affect treatment decisions for patients with LBP.

Clinically Useful

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, more effective therapy, or avoid unnecessary therapy or testing.

Direct Evidence

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from randomized controlled trials.

A number of studies have described SEMG as an aid in classifying LBP.[12,13,14,15,16] Most of this research has focused on the use of SEMG to assess muscle fatigability rather than on how information from test findings could enhance patient management. While SEMG may be used to document muscle spasm or other muscular abnormalities objectively, it is unclear how such objective documentation would supplant or enhance clinical evaluation, or how this information would be used to alter the treatment plan. In part, the difficulty in clinical interpretation is understanding the extent to which the SEMG abnormalities are primary or secondary. Additionally, as noted in the Background section, no specific workup is recommended for acute LBP without warning signs.

The following studies have proposed using SEMG results to inform treatment decisions; however, none provided data to validate whether treatment based on SEMG results in improved outcomes.

In a study of patients with chronic LBP (N=216) by Kienbacher et al (2016), SEMG showed potential to discriminate between impaired and unimpaired neuromuscular regulation of back extensors, which would provide useful information for designing individualized exercise programs.[17]

In a study of patients with LBP (n=27) and pain-free controls (n=23) by Schabrun et al (2017), SEMG detected a loss of discrete motor cortical organization of the paraspinal muscles among those with LBP.[18] The invasive technique of needle electromyography is usually performed to detect this pathology. Patients with cortical reorganization may benefit from motor skill training.

In 2 older studies (1988, 1992), SEMG was shown to differentiate muscle spasm from muscle contracture.[19,20] Muscle spasm would be treated with relaxation therapy, and contracture would be treated with stretching exercises.

Chain of Evidence

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility. Current evidence on clinical validity does not permit construction of a chain of evidence to support the use of SEMG as a diagnostic tool for evaluating and monitoring back pain.

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a U.S. professional society, an international society with U.S. representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to

guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American College of Occupational and Environmental Medicine

In 2019, the guideline from the American College of Occupational and Environmental Medicine on diagnostic tests for low back disorders does not recommend surface electromyography as a technique for diagnosing low back disorders, based on insufficient evidence of efficacy.[2]

North American Spine Society and American Academy of Pain Medicine

In 2020, the North American Spine Society with input from the American Academy of Pain Medicine issued a guideline on the diagnosis and treatment of low back pain.[21] When discussing the diagnostic accuracy of nonimaging tests, the guideline lacks any statement on surface electromyography.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in April 2025 did not identify any ongoing or unpublished trials that would likely influence this review.

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Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Clinical findings (i.e., pertinent symptoms and duration)
  - Comorbidities
  - Activity and functional limitations
  - Reason for procedure/test/device, when applicable

  - Pertinent past procedural and surgical history
  - Past and present diagnostic testing and results
  - Prior conservative treatments, duration, and response
  - Treatment plan (i.e., surgical intervention)
- Consultation and medical clearance report(s), when applicable
- Radiology report(s) and interpretation (i.e., MRI, CT, discogram)
- Laboratory results
- Other pertinent multidisciplinary notes/reports: (i.e., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management), when applicable

Post Service (in addition to the above, please include the following):

- Results/reports of tests performed
- Procedure report(s)

Coding

The list of codes in this Medical Policy is intended as a general reference and may not cover all codes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy.

Type	Code	Description
CPT®	95999	Unlisted neurological or neuromuscular diagnostic procedure
	96002	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles
	97799	Unlisted physical medicine/rehabilitation service or procedure
HCPCS	S3900	Surface electromyography (EMG)

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
12/01/2025	New policy.
05/01/2026	Administrative update. State Guidelines section updated.
06/01/2026	Administrative update. Definitions of Decision Determinations section updated.

Definitions of Decision Determinations

Healthcare Services: For the purpose of this Medical Policy, Healthcare Services means procedures, treatments, supplies, devices, and equipment.

Medically Necessary or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation,

Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

Criteria Determining Experimental/Investigational Status

Below is an excerpt of the language taken from California Children's Services Numbered Letter 05-1020.*

*Department of Healthcare Services Numbered Letter 05-1020. Accessed April 21, 2026, from https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-05-1020-Experimental-and-Investigational-Services.pdf

Policy

A. The California Children's Services (CCS) Program and the Genetically Handicapped Persons Program (GHPP) will not provide coverage for experimental services unless specifically authorized by law.
B. The CCS Program and GHPP may provide coverage for an investigational service if:
    1. It is approved by the FDA under any Investigational New Drug (IND) Application; or
    2. It is authorized for use under the State of California's Right to Try Act; and
    3. Its use is consistent with its FDA-approved IND Application or the State of California's Right to Try Act;
C. Additional criteria that will be considered in the adjudication process include:
    1. Conventional therapy will not adequately treat the intended patient's condition;
    2. Conventional therapy will not prevent progressive disability or premature death;
    3. The provider of the proposed service has a record of safety and success with it or equivalent to that of other providers of the investigational services;
    4. Other criteria (e.g., cost and availability) may be considered in the adjudication of a given request in cases in which more than one investigational service is available;
    5. There is reasonable expectation that the investigational service will significantly prolong the patient's life or will maintain or restore a range of physical and social function suited to activities of daily living; and
    6. The service is not being performed as part of a research study protocol. For a beneficiary with cancer who participates in a clinical trial for cancer, California Health and Safety Code (HSC) § 1370.6 requires that all routine patient care costs related to the clinical trial be covered if the beneficiary's CCS-paneled treating physician recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the enrollee. The coverage does not include investigational services that have not been approved by the FDA and that are associated with the clinical trial.

Feedback

Blue Shield of California Promise Health Plan is interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration. Our medical policies are available to view or download at www.blueshieldca.com/en/bsp/providers.

For medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Questions regarding the applicability of this policy should be directed to the Blue Shield of California Promise Health Plan Prior Authorization Department at (800) 468-9935, or the Complex Case

Management Department at (855) 699-5557 (TTY 711) for San Diego County and (800) 605-2556 (TTY 711) for Los Angeles County or visit the provider portal at www.blueshieldca.com/en/bsp/providers.

Disclaimer: Blue Shield of California Promise Health Plan may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as member health services contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member health services contracts may differ in their benefits. Blue Shield of California Promise Health Plan reserves the right to review and update policies as appropriate.

Appendix A

State Guidelines/Policy Statement (No changes)	
BEFORE	**AFTER**
Paraspinal Surface Electromyography to Evaluate and Monitor Back Pain PHP_2.01.35 **State Guidelines:** Applicable Medi-Cal guidelines as of the publication of this policy (this guideline supersedes the criteria in the Policy Statement section below): I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline: • N/A II. Department of Health Care Services (DHCS) Provider Manual Guideline: • Medicine: Neurology and Neuromuscular (medne neu) • TAR and Non-Standard Benefits List: Codes 90000 thru 99999 (tar and non cd9) • TAR and Non-Standard Benefits List: Codes R0000 thru S9999 (tar and non cdrs) The codes listed on the policy are included in the above Provider Manuals; however, there are no specific clinical guidelines. III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline: • N/A **Policy Statement:** Any criteria that are not specifically addressed in the above Provider Manuals, please refer to the criteria below. I. Paraspinal surface electromyography (SEMG) is considered **investigational** as a technique to diagnose or monitor back pain.	**Paraspinal Surface Electromyography to Evaluate and Monitor Back Pain PHP_2.01.35** **State Guidelines:** Applicable Medi-Cal guidelines as of the publication of this policy (this guideline supersedes the criteria in the Policy Statement section below): I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline: • N/A II. Department of Health Care Services (DHCS) Provider Manual Guideline: • Medicine: Neurology and Neuromuscular (medne neu) • TAR and Non-Standard Benefits List: Codes 90000 thru 99999 (tar and non cd9) • TAR and Non-Standard Benefits List: Codes R0000 thru S9999 (tar and non cdrs) The codes listed on the policy are included in the above Provider Manuals; however, there are no specific clinical guidelines. III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline: • N/A **Policy Statement:** Any criteria that are not specifically addressed in the above Provider Manuals, please refer to the criteria below. I. Paraspinal surface electromyography (SEMG) is considered **investigational** as a technique to diagnose or monitor back pain.