

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination.

Dated: 5/21/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 3/18/2013
Date of Injury: 1/11/2013
IMR Application Received: 4/5/2013
MAXIMUS Case Number: CM13-0000138

- 1) MAXIMUS Federal Services, Inc. has determined the acupuncture sessions, two visits per week for six weeks requested **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the extracorporeal shockwave therapy sessions (left elbow) one visit a week for four weeks requested **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the Electromyography/Nerve conduction velocity (EMG/NCV) of the bilateral upper extremities requested **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 4/5/2013 disputing the Utilization Review Denial dated 3/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 4/24/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the acupuncture sessions, two visits per week for six weeks requested is not medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the extracorporeal shockwave therapy sessions (left elbow) one visit a week for four weeks requested is not medically necessary and appropriate.
- 3) MAXIMUS Federal Services, Inc. has determined the EMG/NCV of the bilateral upper extremities requested is not medically necessary and appropriate.

Medical Qualifications of the Professional Reviewer for treatment request 1:

The independent Doctor of Chiropractic, Licensed Acupuncturist who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Chiropractic and Acupuncture, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The professional reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and treatments and/or services at issue.

Medical Qualifications of the Professional Reviewer for treatment request 2 and 3:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The professional reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated March 18, 2013.

“The claimant presented with complaints of cervical spine pain that radiates to the left upper extremity to the hand with numbness, tingling and weakness. The claimant has left shoulder pain and popping. The claimant also has mild left elbow pain that radiates to the hand. The thoracic spine pain is unchanged. The claimant has received physical therapy. Current requests are for acupuncture sessions (cervical, thoracic, left shoulder/elbow) (two sessions a week for six weeks), extracorporeal shockwave therapy (left elbow)*** frequency and duration not indicated, EMG/NCV of the bilateral upper extremities and pilo-splint of the left elbow.”

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for IMR
- Utilization Review by [REDACTED] (dated 3/18/2013)
- Doctors First Report of Occupational Injury or Illness (dated 01/25/2013)
- Employee's Medical Records by [REDACTED] (dated 1/29/2013 thru 4/4/2013)
- Employee's Medical Records by [REDACTED] (dated 1/24/2013 thru 1/29/2013)
- American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition, 2004 – Chapter 9,10
- Medical Treatment Utilization Schedule (MTUS) 9792.24.1 Acupuncture Medical Treatment Guidelines
- Official Disability Guidelines (ODG) – Low Back; Shoulder; Neck and Upper Back and Elbow sections
- Chronic Pain Treatment Guidelines 9792.20(c)

1) Regarding the Request for acupuncture sessions, two visits per week for six weeks:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition, 2004 – Chapter 10; Medical Treatment Utilization Schedule (MTUS) - Acupuncture Medical Treatment Guidelines; Chronic Pain Treatment Guidelines. The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced sections of the MTUS used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision

The employee states that while at work doing repetitive motion keyboarding and filing they injured their arm, elbow, neck, back and shoulder. The claimant presented with complaints of cervical spine pain that radiates to the left upper extremity to the hand with numbness, tingling and weakness. Prior determination authorized a partial certification of two sessions a week for two weeks of Acupuncture sessions for this patient for the regions of (cervical, thoracic, left shoulder/elbow).

This prior determination is based on both AECOM guideline (9792.24.1) and ODG guidelines Shoulder, Neck, and Upper back for Acupuncture. Both sources recommend a trial of acupuncture initially and further authorization based on functional improvement. Upon detailed review of the submitted documents, there has been no documentation or notes of any acupuncture treatment or functional improvement as a result of an acupuncture trial. Therefore, this request is **not medically necessary and appropriate**.

2) Regarding the Request for extracorporeal shockwave therapy sessions (left elbow) one visit a week for four weeks:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, 2004 - Chapter 10, Page 29; Official Disability Guidelines (ODG) (2009) of the Medical Treatment Utilization Schedule (MTUS) Elbow Procedure Summary. The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced sections of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision

The claimant has mild left elbow pain that radiates to the hand. The claimant has received physical therapy. The evidence and guidelines do not support the use of extracorporeal shockwave therapy for elbow conditions. Specifically, the Official Disability Guidelines specify that extracorporeal shockwave therapy (ESWT) is not recommended. High energy ESWT is not supported, but low energy ESWT may show better outcomes without the need for anesthesia, but is still not recommended. Given the guidelines, this request is **not medically necessary and appropriate**.

3) Regarding the Request for Electromyography/Nerve conduction velocity (EMG/NCV) of the bilateral upper extremities:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, 2004, Page 213, Table 9-6. The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision

The claimant has left shoulder pain and popping. In the case of this injured worker, there is documentation that left cubital tunnel syndrome has been diagnosed clinically based upon the patient's description of left hand numbness. In a note dated 1/30/13, there is documentation of a positive Tinel's sign of the elbow. The assessment section describes "left cubital tunnel" and "left hand radiculopathy." The neurologic examinations from notes dated 1/30/13 and 2/25/13 do not reveal any sensory loss. Symptoms are confined to one side.

To make an assessment of ulnar neuropathy at the elbow, both sides do not need to be assessed as there are established norms for nerve conduction velocity decreases that can signal ulnar neuropathy.

Given the information provided, the request for bilateral upper extremity testing is not warranted. Therefore, the request for bilateral EMG/NCS is **not medically necessary and appropriate**.

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.