RICKMAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

ISSUE(S) AT DISPUTE:

1. MAXIMUS Federal Services, Inc. has determined the physical therapy three (3) times a week for four (4) weeks requested **are not medically necessary and appropriate.**

2. MAXIMUS Federal Services, Inc. has determined the electromyography (EMG) and nerve conduction studies (NCS) of the bilateral upper extremities (BUE) requested **are not medically necessary and appropriate.**

3. MAXIMUS Federal Services, Inc. has determined the magnetic resonance imaging (MRI) (cervical) requested **is not medically necessary and appropriate.**

4. MAXIMUS Federal Services, Inc. has determined the magnetic resonance imaging (MRI) (right shoulder) requested **is not medically necessary and appropriate.**

5. MAXIMUS Federal Services, Inc. has determined the Robaxin requested **is not medically necessary and appropriate.**

6. MAXIMUS Federal Services, Inc. has determined the interferential (IF) Unit requested **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on **5/1/2013** disputing the Utilization Review Denial dated **4/15/2013**. A Notice of Assignment and Request for Information was provided to the above parties on 5/1/2013. A decision has been made for each of the treatment and/or services that were in dispute:

1. The physical therapy three (3) times a week for four (4) weeks requested **are not medically necessary and appropriate.**

2. The electromyography (EMG) and nerve conduction studies (NCS) of the bilateral upper extremities (BUE) requested **are not medically necessary and appropriate.**

3. The magnetic resonance imaging (MRI) (cervical) requested **is not medically necessary and appropriate.**

4. The magnetic resonance imaging (MRI) (right shoulder) requested **is not medically necessary and appropriate.**

5. The Robaxin requested **is not medically necessary and appropriate**.

6. The interferential (IF) Unit requested **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:
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 Occupational Medicine 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 April 15, 2013

"According to the clinical documentation, the patient is a 47-year-old female who sustained an injury on 03/14/13 after extending the arms while assisting a 170-pound client from falling. According to medical report dated 03/26/13 by [redacted], MD, it was documented that there was "right upper extremity/cervical spine, right shoulder, numbness and tingling." There was discoloration of the right flank. There were right elbow pain and headaches, with "left wrist/left upper extremity compensatory pain." The patient medicated with tramadol. On examination, motor strength in the right upper

extremity was decreased at grade 4/5. Previous treatment included completion of 3 sessions of physical therapy which was not helpful. The patient was diagnosed with right upper extremity neuritis/axial loading injury; cervical spine/strain; right shoulder sprain/strain; right elbow sprain/strain; and right wrist sprain/strain."

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 Independent Medical Review (dated 5/1/13)
- Utilization Review Determination performed by [redacted] (dated 4/15/13)
- Medical Records from [redacted] (dated 4/1/13 – 3/18/13)
- Report from [redacted], M.D. (dated 3/21/13)
- Medical Records from [redacted] (dated 3/26/13)
- Report from [redacted], M.D. (dated 3/26/13)
- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Neck and Upper Back Complaints Chapter, pg. 181-183 – Shoulder Complaints Chapter, pg. 211-214
- Official Disability Guidelines (ODG) (2009), Neck and Upper Back – Physical Therapy Section, Shoulder and Forearm - Physical Therapy Section, Wrist and Hand – Physical Therapy Section
- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2008), Shoulder Disorders Chapter, pg. 561-563
- Chronic Pain Medical Treatment Guidelines (2009), pg. 64-65, pg. 118

1) **Regarding the request for** physical therapy three (3) times a week for four (4) weeks **:**

   <u>Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional Reviewer to Make His/Her Decision</u>
   The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Neck and Upper Back Complaints Chapter, pg. 181-183; Shoulder Complaints Chapter, pg. 211-214; and the Forearm, Wrist, and Hand Complaints Chapter, pg 271-273. The Claims Administrator also based its decisions on the Official Disability Guidelines (ODG) Neck and Upper Back (3/11/13), which is a Medical Treatment Guideline not included in the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert 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 experienced pain in the right elbow, headaches, and right upper extremity and cervical spine numbness and tingling after preventing a client from falling on 3/14/2013. Three sessions of physical therapy were documented as not providing improvement. The employee participated in five Occupational Therapy sessions. As of the most recent medical record provided, that of 4/1/2013, the pain has persisted and the employee is not working because the employer is unable to accommodate modified activity. Notes indicate the patient has been unable to perform the home exercise program correctly. The request for twelve additional physical therapy sessions exceeds the limit in the MTUS. The requested twelve physical therapy sessions are not medically necessary and appropriate.

2) **Regarding the request for electromyography (EMG) and nerve conduction studies (NCS) of the bilateral upper extremities (BUE):**

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) Neck and Upper Back Complaints Chapter, pg. 181-183; Shoulder Complaints Chapter, pg. 211-214; and the Forearm, Wrist, and Hand Complaints Chapter, pg 271-273. The Claims Administrator also based its decisions on the Official Disability Guidelines (ODG) Neck and Upper Back (3/11/13); Shoulder (3/7/13); Forearm, Wrist and Hand (3/19/13), which are Medical Treatment Guidelines not included in the MTUS. The Claims Administrator also based its decisions on American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2008) Elbow Disorders Chapter, pg 589-590; and Shoulder Disorders Chapter, pg. 561-563, which are Medical Treatment Guidelines not included in the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert 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 experienced pain in the right elbow, headaches, and right upper extremity and cervical spine numbness and tingling after preventing a client from falling on 3/14/2013. The most current note indicated 4/5 muscle weakness but did not indicate location. There was no sensory deficit or localization of numbness or tingling. The patient does not have a clear documented neurological deficit. The patient has not completed physical and occupational therapy. Criteria for EMG/NCS of the bilateral upper extremities are not met. The requested EMG/NCS of the bilateral upper extremities is not medically necessary and appropriate.

3) **Regarding the request for cervical magnetic resonance imaging (MRI)**

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) Neck and Upper Back Complaints Chapter, pg. 181-183. The Claims Administrator also based its decisions on the Official Disability Guidelines (ODG) Neck and Upper Back (3/11/13), which is a Medical Treatment Guideline not included in the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert 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 employee experienced pain in the right elbow, headaches, and right upper extremity and cervical spine numbness and tingling after preventing a client from falling on 3/14/2013. The most current note indicated 4/5 muscle weakness but did not indicate location. There was no sensory deficit or localization of numbness or tingling. Criteria for a cervical MRI are not met. The requested cervical MRI is not medically necessary and appropriate.

4) **Regarding the request for right shoulder magnetic resonance imaging (MRI):**

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) Shoulder Complaints Chapter, pg. 211-214. The Claims Administrator also based its decisions on the Official Disability Guidelines (ODG) Shoulder (3/7/13) which is a Medical Treatment Guideline not included in the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert 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 employee experienced pain in the right elbow, headaches, and right upper extremity and cervical spine numbness and tingling after preventing a client from falling on 3/14/2013. The most current note indicated 4/5 muscle weakness but did not indicate location. There was no sensory deficit or localization of numbness or tingling. There was no mention of a shoulder deficit or lesion. The

patient has not completed physical and occupational therapy. Criteria for an MRI of the shoulder are not met. The requested MRI of the right shoulder is not medically necessary and appropriate.

5) Regarding the request for Robaxin

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 Chronic Pain Medical Treatment Guidelines (2009), Robaxin, pg. 64-65, of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert 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 employee experienced pain in the right elbow, headaches, and right upper extremity and cervical spine numbness and tingling after preventing a client from falling on 3/14/2013. The most current note indicated 4/5 muscle weakness but did not indicate location. There was no sensory deficit or localization of numbness or tingling. There is no documented spasm or muscle tightness, which are reasons to prescribe a muscle relaxant. Analgesics were provided. Criteria for prescribing Robaxin are not met. The requested Robaxin is not medically necessary and appropriate.

6) Regarding the request for an Interferential Frequency (IF) Unit

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 Chronic Pain Medical Treatment Guidelines (2009), Inferential Current Stimulation, pg. 118, of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert 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 employee experienced pain in the right elbow, headaches, and right upper extremity and cervical spine numbness and tingling after preventing a client from falling on 3/14/2013. The most current note indicated 4/5 muscle weakness but did not indicate location. There was no sensory deficit or localization of numbness or tingling. There is no documented spasm or muscle tightness. The patient has not completed an adequate trial of conservative care. Criteria for an Inferential Current Stimulation are not met. The requested Inferential Current Stimulation 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.