
Notice of Independent Medical Review Determination

Dated: 8/19/2013

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Date of UR Decision:

[REDACTED]

5/30/2013

Date of Injury:

1/5/2013

IMR Application Received:

7/5/2013

MAXIMUS Case Number:

CM13-0000980

- 1) MAXIMUS Federal Services, Inc. has determined the request for chiropractic treatments, 2 times a week for 4 weeks, for the left shoulder, left wrist, left elbow/arm, and the lumbar spine **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an EMG/NCV for the bilateral lower extremities **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/5/2013 disputing the Utilization Review Denial dated 5/30/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/8/2013. 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 request for chiropractic treatments, 2 times a week for 4 weeks, for the left shoulder, left wrist, left elbow/arm, and the lumbar spine **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an EMG/NCV for the bilateral lower extremities **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 Expert 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 May 30, 2013

"This claimant is a 35 year old male who sustained a work related injury on 1-5-13 from an unknown mechanism. Work status :Remain off work until 7-9-13. Reported Diagnoses are left shoulder and left wrist strain and sprain. Left elbow medial epicondylitis. Prior treatments include chiro. Current medications are not specified. Per progress report dated 5-21-13 the claimant is complaining of pain in the neck, mid back, low back, left shoulder and left wrist. Pain radiates from the neck to the upper extremities to the hands with numbness and bilateral lower extremities to the feet with burning. Physical examination reveals C-spine limited ROM and TTP left paracervicals. Left shoulder limited ROM, positive cross arm, TTP AC joint, mid back paraspinals. Lumbar spine limited ROM and TTP L 1-S1 with positive SLR. Left wrist: TTP volar ligament and positive Tinel's.

"Request is for Chiro 2x4 for the Left shoulder, Left wrist, Left Elbow/Arm, Lumbar Spine; EMG/NCV for bilateral lower extremities."

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 (received 7/5/13)
- Utilization Review Determination (dated 5/30/13)
- Employee medical records from [REDACTED] (dated 4/15/13-7/2/13)
- Employee medical records from S [REDACTED] (dated 4/16/13-7/1/13)
- Employee medical records from [REDACTED] (dated 1/5/13-5/17/13)
- Employee medical records from [REDACTED] (dated 1/8/13-2/22/13)
- Employee medical records from [REDACTED] (dated 5/14/13)
- Employee medical records from [REDACTED] (dated 2/13/13)
- Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), pg. 203-204
- Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), pg. 298-308
- Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), pg.263-266

1) Regarding the request for chiropractic treatments, 2 times a week for 4 weeks, for the left shoulder, left wrist, left elbow/arm, and the lumbar spine:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), pg. 203-204; Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), pg. 298-308; Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), pg.263-266, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found that the guidelines used by the Claims Administrator were not appropriate for the employee's clinical circumstance. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 58 of 127, which is part of the Medical Treatment Utilization Schedule (MTUS), relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury to the left shoulder, left elbow, and left wrist pain on associated with cumulative trauma date of 1/5/13. Medical records provided and reviewed indicate treatment has consisted of analgesic medications, unspecified amounts of chiropractic treatment, lumbar support, and time off of work. The medical report of 6/26/13 is notable for persistent neck, shoulder, wrist, and low back pain with numbness and tingling about the bilateral lower extremities, exacerbated by lifting, bending, and twisting, and restricted

lumbar, cervical, and left shoulder range of motion with associated tenderness to touch. The employee is now more than seven months post injury and has failed to progress as expected, meeting the criteria for chronic pain. The request is for chiropractic treatments, 2 times a week for 4 weeks, for the left shoulder, left wrist, left elbow/arm, and the lumbar spine.

While the MTUS Chronic Pain Medical Treatment Guidelines do endorse up to 18 sessions of manipulative therapy for those individuals who demonstrate evidence of functional improvement and/or return to work, in this case, there is no evidence of functional improvement based on the completed treatments which might meet the criteria for additional chiropractic treatment. The chiropractic treatments, 2 times a week for 4 weeks, for the left shoulder, left wrist, left elbow/arm, and the lumbar spine, **are not medically necessary and appropriate.**

2) Regarding the request for an EMG/NCV for the bilateral lower extremities :

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), pg. 261, 269, 272, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found that the guidelines used by the Claims Administrator were not appropriate for the employee's clinical circumstance. The Expert Reviewer found the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), 303, 309, which is part of the Medical Treatment Utilization Schedule (MTUS), addressed the EMG portion of the issue at dispute. The Expert Reviewer stated that MTUS does not specifically address the issue of NCV, and, additionally, based his/her decision on the ACOEM Practice Guidelines 2nd Ed., Update to Chapter 12, Low Back Disorders, pg. 60-61, which is not part of the MTUS, as relevant and appropriate for the NCV portion of the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury to the left shoulder, left elbow, and left wrist associated with a cumulative trauma date of 1/5/13. Medical records provided and reviewed indicate treatment has consisted of analgesic medications, unspecified amounts of chiropractic treatment, lumbar support, and time off of work. The medical report of 6/26/13 is notable for persistent neck, shoulder, wrist, and low back pain with numbness and tingling about the bilateral lower extremities, exacerbated by lifting, bending, and twisting, and restricted lumbar, cervical, and left shoulder range of motion with associated tenderness to touch. The request is for an EMG/NCV of the bilateral lower extremities.

While EMG testing, per the MTUS-adopted ACOEM guidelines can be useful to identify subtle, focal neurologic dysfunction in those individuals with persistent

back complaints, the MTUS does not address the topic of NCV testing. The updated ACOEM guidelines suggest that NCV testing is generally normal in radiculopathy, and further notes that other conditions, such as peripheral neuropathy, may generate symptoms which may mimic sciatica. In this case, however, no clear diagnosis or differential diagnosis has been proffered by the attending provider. The medical records provided for review do not support suspicion of lower extremity peripheral neuropathy or similar diagnoses for which NCV testing would more clearly be indicated. The EMG/NCV for the bilateral lower extremities **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

/dl

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.



