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**Notice of Independent Medical Review Determination**

Dated: 8/23/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/2/2013

10/1/2012

7/9/2013

CM13-0001054

- 1) MAXIMUS Federal Services, Inc. has determined the request for EMG, Left Upper Extremity **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for NCV, Left Upper Extremity **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for NCV, Right Upper Extremity **is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for EMG, Right Upper Extremity **is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/9/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/10/2013. 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 EMG, Left Upper Extremity **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for NCV, Left Upper Extremity **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for NCV, Right Upper Extremity **is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for EMG, Right Upper Extremity **is 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 Physical Medicine and Rehabilitation, 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 July 2, 2013

"Injured worker complains of pain on the cervical and lumbar area. Cervical spine examination shows spasms noted at C3-C7 without pain and deformity. Range of motion is 50 percent normal. Spurling's test show arm pain on the left side. Lumbar Spine examination on palpation reveal spasms noted at L3-S1, patient walks with a limp; straight leg raise test is positive at 30 degrees on supine. X-ray of the cervical spine shows no significant disc narrowing. X-ray of the lumbar spine shows some evidence of disc herniation throughout between 1 and 3 mm with moderately significantly narrowing of the neural foramen bilaterally. MRI of the lumbar spine (no plates available) reveals large disc herniation at L4-L-5 and L1-S-1 with 12 mm of antherolsthesis of L5 over S1 and pressure traversing both L5 nerve roots with marded narrowing of both neural foramina at L5-S1. The patient had medication management and activity modification plus conservative treatment. Request is made for lumbar support and nerve studies. Requesting authorization for Lumbar Support Brace, EMV/NCV for Right lower Extremity, EMG/NCV for Left Lower extremity".

## 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 7/9/2013)
- Utilization Review from [REDACTED] (dated 7/3/2013)
- Medical Records from [REDACTED], MD (dated 10/1/12; 6/14/13)
- Medical Records from [REDACTED] (dated 11/15/12; 11/27/12; 12/26/12; 1/4/13; 1/11/13)
- Medical Records from [REDACTED] (dated 11/15/12; 12/10/12; 12/18/12; 12/28/12; 1/9/13; 1/11/13; 1/16/13; 1/22/13; 2/8/13; 2/12/13; 2/15/13; 2/21/13; 2/22/13)
- Medical Records from [REDACTED], DC, QME (dated 11/16/12)
- Medical Records from [REDACTED], MD (dated 1/25/13; 2/22/13)
- Medical Records from [REDACTED], MD (dated 2/12/13)
- Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004) Chapter 8) into the MTUS from the ACOEM Practice Guidelines. Table 8-8.

### 1) Regarding the request for EMG, Left Upper Extremity :

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

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004) Chapter 8), Table 8-8, 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 based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 8), pg. 178, MTUS as relevant and appropriate for the issue at dispute.

#### Rationale for the Decision:

The employee sustained a work-related injury on 10/01/12 to the neck, upper back, mid and lower back, and right hip. The medical records provided for review indicate continued cervical pain radiating into the arms with numbness in the hands, especially with activity. The 6/14/13 medical record documents decreased grip strength and decreased circumference of the right forearm compared to the left as well as a positive Spurling's test producing left arm pain. The request is for EMG of the left upper extremity.

ACOEM guidelines indicate EMG/NCV is appropriate to identify subtle focal neurologic dysfunction when neck or arm symptoms last longer than three to four weeks. Medical records reviewed indicate subjective complaints and objective findings suggestive of either cervical radiculopathy down both arms/hands or peripheral neuropathy of both hands. **EMG of the left upper extremity is medically necessary and appropriate.**

## 2) Regarding the request for NCV, Left Upper Extremity:

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

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004) Chapter 8), Table 8-8, 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 based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 8), pg. 178, MTUS as relevant and appropriate for the issue at dispute.

### Rationale for the Decision:

The employee sustained a work-related injury on 10/01/12 to the neck, upper back, mid and lower back, and right hip. The medical records provided for review indicate continued cervical pain radiating into the arms with numbness in the hands, especially with activity. The 6/14/13 medical record documents decreased grip strength and decreased circumference of the right forearm compared to the left as well as a positive Spurling's test producing left arm pain. The request is for EMG of the left upper extremity.

ACOEM guidelines indicate EMG/NCV is appropriate to identify subtle focal neurologic dysfunction when neck or arm symptoms last longer than three to four weeks. Medical records reviewed indicate subjective complaints and objective findings suggestive of either cervical radiculopathy down both arms/hands or peripheral neuropathy of both hands. NCV of the left upper extremity **is medically necessary and appropriate.**

## 3) Regarding the request for NCV, Right Upper Extremity:

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

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004) Chapter 8), Table 8-8, 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 based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 8), pg. 178, MTUS as relevant and appropriate for the issue at dispute.

### Rationale for the Decision:

The employee sustained a work-related injury on 10/01/12 to the neck, upper back, mid and lower back, and right hip. The medical records provided for review

indicate continued cervical pain radiating into the arms with numbness in the hands, especially with activity. The 6/14/13 medical record documents decreased grip strength and decreased circumference of the right forearm compared to the left as well as a positive Spurling's test producing left arm pain. The request is for EMG of the left upper extremity.

ACOEM guidelines indicate EMG/NCV is appropriate to identify subtle focal neurologic dysfunction when neck or arm symptoms last longer than three to four weeks. Medical records reviewed indicate subjective complaints and objective findings suggestive of either cervical radiculopathy down both arms/hands or peripheral neuropathy of both hands. NCV of the right upper extremity **is medically necessary and appropriate.**

#### **4) Regarding the request for EMG, Right Upper Extremity:**

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

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004) Chapter 8), Table 8-8, 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 based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 8), pg. 178, MTUS as relevant and appropriate for the issue at dispute.

##### Rationale for the Decision:

The employee sustained a work-related injury on 10/01/12 to the neck, upper back, mid and lower back, and right hip. The medical records provided for review indicate continued cervical pain radiating into the arms with numbness in the hands, especially with activity. The 6/14/13 medical record documents decreased grip strength and decreased circumference of the right forearm compared to the left as well as a positive Spurling's test producing left arm pain. The request is for EMG of the left upper extremity.

ACOEM guidelines indicate EMG/NCV is appropriate to identify subtle focal neurologic dysfunction when neck or arm symptoms last longer than three to four weeks. Medical records reviewed indicate subjective complaints and objective findings suggestive of either cervical radiculopathy down both arms/hands or peripheral neuropathy of both hands. EMG of the right upper extremity **is 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, 18<sup>th</sup> 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.