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**Notice of Independent Medical Review Determination**

Dated: 9/18/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/5/2013
Date of Injury:	11/1/2012
IMR Application Received:	7/16/2013
MAXIMUS Case Number:	CM13-0001702

- 1) MAXIMUS Federal Services, Inc. has determined the request for an EMG of the left upper extremity **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an EMG of the right upper extremity **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/16/2013 disputing the Utilization Review Denial dated 7/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/18/2013. 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 an EMG of the left upper extremity **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an EMG of the right upper extremity **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 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 5, 2013

“Issue(s) to be analyzed: Is EMG of Right and Left Upper Extremity Medically Necessary? Nurse Clinical summary: DOI 11/01/12 DOE 6/14/13 Injured worker complains of right shoulder pain level that remained unchanged. There is tenderness to palpation on the subdeltoid bursa and with negative joint stability and negative biceps pathology of the right shoulder. Right wrist shows swelling with tenderness to palpation over the volar crease. There is also tenderness to palpation over the right hand on the proximal interphalangeal joint of the index finger and distal interphalangeal joint of the index finger. Finkelsteina¿¿ test is positive. Request is made for EMG/NCV of the right and left upper 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 (received 7/16/13)
- Utilization Review Determination (dated 7/5/13)\
- American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2008), Chapter 8-Neck and Upper Back Complaints, Table 8-8 Summary of Recommendation for Evaluating and Managing Neck and Upper Back Complaints, pg. 537

- Medical Records from [REDACTED] (dated 2/5/13-4/15/13)
- Medical Records from [REDACTED], M.D., QME (dated 5/28/13-7/11/13)
- PR-2 Reports from [REDACTED], MD (dated 1/23/13-7/23/13)
- Progress notes from [REDACTED] (dated 12/19/12-1/3/13)
- Doctors first report from [REDACTED], MD (dated 12/13/12)

**1) Regarding the request for an EMG of 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 American College of Occupational and Environmental Medicine (ACOEM), (2007), Chapter 8-Neck and Upper Back Complaints, Table 8-8 Summary of Recommendation for Evaluating and Managing Neck and Upper Back Complaints, pg. 537, a medical treatment guidelines (MTG) not part of the Medical Treatment Utilization Schedule (MTUS), and the Official Disability Guidelines (ODG) (current version), Chapter, Neck & Upper, a MTG not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Chapter 8 – Neck and Upper Back Complaints, pg. 178, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 11/01/12 the employee sustained an injury to the right shoulder, right wrist, right hand and index finger. The submitted and reviewed medical records indicate treatment has included: a course of physical therapy and medication. A medical report dated 6/14/13 indicates unchanged pain in the right shoulder. A request was submitted for an EMG of the left upper extremity.

MTUS ACOEM guidelines state EMG studies “may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks”. The medical records reviewed do not provide evidence to suggest focal neurologic dysfunction in either the cervical spine or upper extremities. The request for EMG of the left upper extremity is not in accordance with MTUS guidelines. The request for EMG of the left upper extremity **is not medically necessary and appropriate.**

**2) Regarding the request for an EMG of 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 American College of Occupational and Environmental Medicine (ACOEM), (2007), Chapter 8-Neck and Upper Back Complaints, Table 8-8 Summary of Recommendation for Evaluating and Managing Neck and Upper Back Complaints, pg. 537, a medical treatment guidelines (MTG) not part of the Medical Treatment Utilization Schedule (MTUS), and the Official Disability Guidelines (ODG) (current version), Chapter, Neck & Upper, a MTG not part of the MTUS. The provider did not

dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Chapter 8 – Neck and Upper Back Complaints, pg. 178, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 11/01/12 the employee sustained an injury to the right shoulder, right wrist, right hand and index finger. The submitted and reviewed medical records indicate treatment has included: a course of physical therapy and medication. A medical report dated 6/14/13 indicates unchanged pain in the right shoulder. A request was submitted for an EMG of the right upper extremity.

MTUS ACOEM guidelines state EMG studies “may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks”. The medical records reviewed do not provide evidence to suggest focal neurologic dysfunction in either the cervical spine or upper extremities. The request for EMG of the left upper extremity is not in accordance with MTUS guidelines. The request for EMG of the right upper extremity **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, 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.