

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



---

**Notice of Independent Medical Review Determination**

Dated: 10/30/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/5/2013
Date of Injury:	6/21/2010
IMR Application Received:	7/24/2013
MAXIMUS Case Number:	CM13-0002813

- 1) MAXIMUS Federal Services, Inc. has determined the request for EMG of the right upper extremity **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for NCS of the right upper extremity **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for massage therapy to the neck and shoulder two (2) times a week for four (4) weeks **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/30/2013. 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 of the right upper extremity **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for NCS of the right upper extremity **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for massage therapy to the neck and shoulder two (2) times a week for four (4) weeks **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 Orthopedic Surgery, 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:

“This is a 58 year-old female [REDACTED] employed by [REDACTED] who sustained an industrial injury to her neck, back, and knees on 6/21/10 that resulted from a slip and fall at work. The patient has come under the care of Dr. [REDACTED], MD/ortho spine who is treating the patient for lumbar disc displacement; cervical disc degeneration; spinal stenosis of the lumbar spine.”

This 58 year old claimant sustained a work-related injury on 6/21/10 in a slip and fall at work. She is currently diagnosed with cervical disc degeneration and sprain of neck.

Per Dr. [REDACTED] note, diagnostic testing has included an MRI of the cervical spine on 4/11/13 reveals mild disc desiccation at C3-4, C4-5, and C5-6, with mild central canal stenosis at C3-4 and C5-6. Per Dr. [REDACTED] note of 3/14/13, “An electromyography has been done a few years ago and did show right ulnar neuropathy but no treatment. It was negative for carpal tunnel syndrome.”

Conservative care for her neck injury has included physical therapy (last visit 2011), a home exercise program, activity modification, narcotic analgesics, anti-inflammatory medications, Cymbalta, and Valium.

On 6/25/13 visit with Dr. [REDACTED] (Orthopedic Surgery), the claimant complained of neck, right trapezius, and periscapular pain as well as tingling and numbness from the right elbow down the ulnar digits of her right arm. On exam, there was limitation in neck range of motion with flexion and extension to about 50% of normal, right rotation 45% of normal, and left rotation 60% of normal. There was a positive Spurling's sign to the left. There was a positive Tinel's sign across the right cubital tunnel with diminished sensation in the other digits of the right hand. The left upper extremity was normal. The impression was cervical disc degeneration and sprain of neck. The plan was to request authorization for massage therapy to the neck and shoulder areas 2 times per week for 4 weeks. Dr. [REDACTED] stated he was also requesting authorization for an electromyography study of her right upper extremity. She was to remain off work for another 6 months.

On 7/16/13 visit with Dr. [REDACTED] the subjective complaints and exam were unchanged from the prior exam. Regarding the plan of care, Dr. [REDACTED] stated he was appealing the denial of a right upper extremity electromyography/nerve conduction study to determine whether the symptoms were coming from the cubital tunnel pathology versus cervical spine. He noted that the cervical spine findings were mild in nature and cannot fully explain the extent of her right arm paresthesia. He was also appealing the denial of massage therapy to the neck and shoulder. Dr. [REDACTED] stated he felt the claimant would benefit from massage as an adjunct to her current home exercise program.

Utilization Review on 7/5/13 by Dr. [REDACTED] (Occupational Medicine) determined that the electromyography and nerve conduction study of right upper extremity were non-certified, as there was no documentation of failure of conservative treatment targeting the right elbow, or that symptoms were significantly changed since the last study, nor were copies made available of prior studies. Massage therapy to neck and shoulder was non-certified, as there was no documentation of massage being used as an adjunct to a program of therapeutic rehabilitative exercise to improve function or a statement of exceptional factors explaining the medical necessity for exceeding recommendations for treatment limiting massage to no more than 4-6 visits.

An appeal is being requested for an electromyography of the right upper extremity, a nerve conduction study of the right upper extremity, and massage therapy to the neck and shoulder two (2) times a week for four (4) weeks.

#### **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
- Utilization Review Determination from Claims Administrator
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

## 1) Regarding the request for EMG of the 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), 2<sup>nd</sup> Edition, (2004), Elbow Disorders Chapter, pgs. 601-602 which is part of MTUS.

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, and the Elbow Disorders Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (Revised 2007), Chapter 10) pg. 33, and the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11) pg. 261 which are part of the MTUS

### Rationale for the Decision:

The employee sustained a work-related injury on 06/21/2010. Medical records provided for review indicate treatments have included physical therapy, a home exercise program, activity modification, medications for various symptoms, diagnostic testing, electrodiagnostic testing, surgical intervention, cervical radiofrequency ablation, epidural steroid injections, and a trochanteric injection. The request is for electromyography (EMG) of the right upper extremity.

The MTUS/ACOEM Guidelines indicate that nerve conduction studies and possibly EMGs are indicated in individuals who fail to respond to conservative care. Both diagnostic studies are an option for individuals where radiculopathy and/or peripheral nerve entrapment is a consideration. The medical records provided for review indicate the employee has clinical complaints consistent with peripheral nerve entrapment and/or cervical radiculopathy, and/or potentially a double-crush phenomenon. **The request for EMG of the right upper extremity is medically necessary and appropriate.**

## 2) Regarding the request for NCS of the 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), 2<sup>nd</sup> Edition, (2008), Elbow Disorders Chapter, pgs. 601-602, which is part of the Medical Treatment Utilization Schedule (MTUS).

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, and the Elbow Disorders Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (Revised 2007), Chapter 10) pg. 33, and the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11) pg. 261 which are part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 06/21/2010. Medical records provided for review indicate treatments have included physical therapy, a home exercise program, activity modification, medications for various symptoms, diagnostic testing, electrodiagnostic testing, surgical intervention, cervical radiofrequency ablation, epidural steroid injections, and a trochanteric injection. The request is for nerve conduction studies (NCS) of the right upper extremity.

The MTUS/ACOEM Guidelines indicate that that nerve conduction studies and possibly EMGs are indicated in individuals who fail to respond to conservative care. They are an option in individuals where radiculopathy and/or peripheral nerve entrapment is a consideration. The medical records provided for review indicate the employee has clinical complaints consistent with peripheral nerve entrapment and/or cervical radiculopathy, and/or potentially a double-crush phenomenon. **The request for NCS of the right upper extremity is medically necessary and appropriate.**

**3) Regarding the request for massage therapy to the neck and shoulder two (2) times a week for four (4) weeks:**

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Massage Therapy, pg. 60, which is a part of the Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Massage therapy, which are part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 06/21/2010. The medical records provided for review indicate treatments have included physical therapy, a home exercise program, activity modification, medications for various symptoms, diagnostic testing, electrodiagnostic testing, surgical intervention, cervical radiofrequency ablation, epidural steroid injections, and a trochanteric injection. The request is for massage therapy to the neck and shoulder two (2) times a week for four (4) weeks.

The MTUS/Chronic Pain guidelines do not recommend massage therapy. The guidelines recommend massage therapy as an option as an adjunct to other recommended treatments such as exercise and should be limited to four to six visits. The request in this particular case is for eight visits, which would be outside the typical number of recommended sessions. Furthermore, this employee is more than three years from the date of injury, and there is limited discussion as to the extent or nature of conservative care that has been recently performed. It is noteworthy that years earlier this gentleman had been through an exercise program, physical therapy, and transitioned to a home exercise program. It is unclear for the records reviewed as to the benefits of massage therapy for this claimant with chronic complaints who already appears to have

exhausted conservative care. **The request for massage therapy to the neck and shoulder two (2) times a week for four (4) weeks 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

/ejf

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.