

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 10/21/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/12/2013
Date of Injury:	1/7/2009
IMR Application Received:	7/24/2013
MAXIMUS Case Number:	CM13-0002922

- 1) MAXIMUS Federal Services, Inc. has determined the requested repeat EMG bilateral upper extremity **is 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 7/12/2013. 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 requested repeat EMG bilateral 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 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 July 12, 2013

Claimant had previous EMG, results not seen. Claimant underwent right median nerve neural ices/decompression and tenosynovectomy of the flexor tendons on 1/30/13. On 7/3/13 claimant had complaint of right wrist pain with episodes and numbness but very little pain noted. Claimant rates pain 3-4/10. claimant also complains of left wrist pain. No tenderness or palpation is noted in the right wrist. Left wrist Phalen's showed numbness and tingling on the median nerve distribution. No tenderness or palpation is reported.

### **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 7/24/13)
- Utilization Review Determination from [REDACTED] (dated 7/12/13)
- Medical Treatment Utilization Schedule (MTUS)

**Note: Medical records were not submitted timely by the Claims Administrator.**

### **1) Regarding the request for repeat EMG bilateral 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 Official Disability Guidelines (ODG) (current version), NCS extremity, which is not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the

guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), Chapter 11: Forearm, Wrist, and Hand Complaints, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 1/7/2009. No medical records were provided for review. The Utilization Review determination dated 7/12/2013 documents that the employee is status post prior carpal tunnel release surgery, has complaints of right wrist pain with episodic numbness, and also has numbness and tingling of the left wrist with positive Phalen's sign. The request is for EMG bilateral upper extremity.

The MTUS/ACOEM Guidelines indicate that electrodiagnostic testing can be repeated later in a treatment course if symptoms persist. No medical records were provided for review, but the Utilization Review determination indicates that that the employee has remaining symptoms of persistent pain and paresthesias which would meet guideline criteria for repeat studies. The request for EMG bilateral 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.