

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
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Notice of Independent Medical Review Determination

Dated: 10/23/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/12/2013
Date of Injury: 5/21/2013
IMR Application Received: 7/25/2013
MAXIMUS Case Number: CM13-0003232

- 1) MAXIMUS Federal Services, Inc. has determined the request for EMG - left upper extremity **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for NCV - left upper extremity **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for qualified functional capacity evaluation **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for 3D MRI - right elbow **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for a multi-interferential stimulator **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for range of motion measurement **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. 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 not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for NCV - left upper extremity **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for qualified functional capacity evaluation **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for 3D MRI - right elbow **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for a multi-interferential stimulator **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for range of motion measurement **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 12, 2013.

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CLINICAL SUMMARY: [REDACTED] is a 52 year old (DOB: [REDACTED]) female rehabilitation therapist

injured on 5/21/13. Right elbow, right wrist, right hand have been accepted by the carrier. Right shoulder has been denied by the carrier. Work status: modified duty

PRIOR UR: none reviewed

DIAGNOSTICS: none reviewed

PRIOR SURGERY/PROCEDURES:

2/2010 left knee replaced

MEDICAL RECORD SUMMARY:

-7/1/13 [REDACTED] M.D. Request for authorization. Diagnosis: Bursitis and tendinitis of right shoulder 726.10, partial tear of rotator cuff tendon 726.13, medial epicondylitis of the right elbow 726.31, Lateral epicondylitis of the right elbow 726.31, Right olecranon bursitis 726.33, R/o carpal tunnel syndrome (median nerve entrapment at right wrist) 354.0, Tendinitis: Bursitis of the right hand/wrist 726.4, Carpometacarpal sprain/strain of right wrist. 842.11.
Requested: Follow up visits 99214 with range of motion measurement 95851. Therapy 6 visits at 3 times weekly for 2 weeks. Electrical muscle stimulation 97014 to the right shoulder. Infrared 97026 to the right shoulder and right elbow. Paraffin 97018 to the right hand. Myofascial release 97250 to the right shoulder and right elbow right wrist wrist stretches

-7/1/13 [REDACTED] M.D. Request for authorization. Requested NCV and EMG of the NCV/BMG testing of the bilateral upper extremities 95861 95904 One evaluation

-7/1/13 [REDACTED] M.D. Request for authorization. Requested: Qualified Functional Capacity Evaluation 97670 One evaluation

-7/1/13 [REDACTED] M.D.; Initial Evaluation and Report: IW injured her right elbow, right wrist, right forearm, and right shoulder while opening a door that was broken and would skid and jam on the floor. Past Treatment: Treatment at [REDACTED] IW obtained an x-ray of the elbow and was told the elbow was not fractured. She was diagnosed with strain of the forearm. She participated in 9 physical therapy session, and had a cortisone shot to the right elbow. The doctor ordered an MRI of the right elbow. Present complaints: Right shoulder: constant severe pain that the patient described as sharp. Right elbow: Constant severe pain that the patient described as sharp. Right wrist and Hand: Frequent moderate pain described as numbness, burning. The patient filled out the Epworth Sleepiness Scale and scored 12 out of a possible 14. A score of 8 and above is considered a positive score and may indicate the need for further study. Shoulder exam: +4 spasm and tenderness to the right rotator cuff muscles and right upper shoulder muscles. Shoulder ROM (Active): Flexion 115/180 painful, Extension 40/45. Abduction: 90/180 painful. Adduction: right 40/45 painful. External rot. 60/90 painful. Internal rot. 70/90 painful. Shoulder range of motion was captured digitally by Acumar. Codman's test was positive on the right. Speeds test was positive on the right. Supraspinatus test was positive on the right. Elbow exam: +4 spasm and tenderness to the right medial and lateral epicondyles and right olecranon. Elbow ROM (Active) Flexion: 120/140 painful. Extension -5/0 painful. Supination: 60/90 painful. Pronation 60/90 painful

Valgus test was positive on the right. Varus test was negative. Cozen's test was positive on the right. Reverse Cozen's test was positive on the right.
Wrist and hand exam: +4 spasm and tenderness to the right anterior wrist and right posterior extensor tendons
Wrist ROM (Active)
Flexion: 40/85 painful. Extension 40/80 painful. Radial Dev. 10/20 painful. Ulnar dev. 20/40 painful.
Tinel's (carpal) test was negative.
Tinel's (Guyon) test was negative
Bracelet test was positive on the right.
Phalen's was positive on the right
Diagnosis: Bursitis and tendinitis of right shoulder 726.10

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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 7/25/13)
- Utilization Review Determination from [REDACTED] (dated 7/12/13)
- Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for EMG - left upper extremity :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Claims Administrator based its decision on the Elbow Disorders Chapter (ACOEM Practice Guidelines, 2nd Edition (Revised 2007), Chapter 10), no section or page cited, part of the MTUS. The Expert Reviewer found the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), Carpal Tunnel Syndrome, pages 260-262, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained an industrial related injury to the right elbow on 5/21/13. A review of the medical records submitted indicates treatments have included: physical therapy, cortisone injection, and return to work with modifications. A request was submitted for an EMG for left upper extremity, NCV for left upper extremity, a qualified functional capacity evaluation, 3D MRI to the right elbow, a multi-interferential stimulator and range of motion measurement.

ACOEM Guidelines state, "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy." A review of the medical records submitted indicates the employee sustained the injury to the right elbow and has pain in the right shoulder and hand. The medical records do not document that the employee has any complaints or objective findings for the left upper extremity. The request for EMG for the left upper extremity **is not medically necessary and appropriate.**

2) Regarding the request for NCV - left upper extremity :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Claims Administrator based its decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), section or page cited, part of the MTUS. The Expert Reviewer found the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), Carpal Tunnel Syndrome, pages 260-262, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained an industrial related injury to the right elbow on 5/21/13. A review of the medical records submitted indicates treatments have included: physical therapy, cortisone injection, and return to work with modifications. A request was submitted for an EMG for left upper extremity, NCV for left upper extremity, a qualified functional capacity evaluation, 3D MRI to the right elbow, a multi-interferential stimulator and range of motion measurement.

ACOEM Guidelines state, "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy." A review of the medical records submitted indicates the employee sustained the injury to the right elbow and has pain in the right shoulder and hand. The medical records do not document that the employee has any complaints or objective findings for the left upper extremity. The request for NCV for the left upper extremity **is not medically necessary and appropriate.**

3) Regarding the request for qualified functional capacity evaluation :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Claims Administrator based its decision on the Official Disability Guidelines (ODG) Treatment, Integrated Treatment, Disability Duration Guidelines for performing an FCE, a Medical Treatment Guideline (MTG), not part of the MTUS. The Expert Reviewer found no section of the MTUS applicable and relevant to the issue at dispute. The Expert Reviewer found the American College of Occupational and Environmental medicine (ACOEM), 2nd Edition, (2004) Chapter 7, no section cited, pages 137-138, a Medical Treatment Guideline (MTG), not part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained an industrial related injury to the right elbow on 5/21/13. A review of the medical records submitted indicates treatments have included: physical therapy, cortisone injection, and return to work with modifications. A request was submitted for an EMG for left upper extremity, NCV for left upper extremity, a qualified functional capacity evaluation, 3D MRI to the right elbow, a multi-interferential stimulator and range of motion measurement.

ACOEM guidelines state, "There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace". "As with any

behavior, an individual's performance on an FCE (functional capacity evaluation) is probably influenced by multiple nonmedical factors other than physical impairments. For these reasons, it is problematic to rely solely upon the FCE results for determination of current work capability and restrictions". A review of the submitted medical records indicates that the employee initially had right elbow pain with reduced motion and inflammation. The records indicate inflammation and motion improved with physical therapy, there was some residual pain, and the employee returned to work with modified duty. The FCE was requested for a baseline; however, an evaluation performed on 7/1/13 had already provided the baseline and included some additional body regions, which were not reported on the patient's initial statement on 5/22/13. The request for a qualified functional capacity evaluation **is not medically necessary and appropriate.**

4) Regarding the request for 3D MRI - right elbow :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) Treatment, Integrated Treatment, Disability Duration Guidelines for Magnetic resonance imaging (MRI), a Medical Treatment Guideline (MTG), not part of the MTUS. The Expert Reviewer found the Elbow Disorders Chapter (ACOEM Practice Guidelines, 2nd Edition (Revised 2007), Chapter 10), Special studies and Diagnostic and Treatment considerations, pages 33-34, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained an industrial related injury to the right elbow on 5/21/13. A review of the medical records submitted indicates treatments have included: physical therapy, cortisone injection, and return to work with modifications. A request was submitted for an EMG for left upper extremity, NCV for left upper extremity, a qualified functional capacity evaluation, 3D MRI to the right elbow, a multi-interferential stimulator and range of motion measurement.

The MTUS/ACOEM guidelines state, "For patients with limitations of activity after 4 weeks and unexplained physical findings such as effusion or localized pain (especially following exercise), imaging may be indicated to clarify the diagnosis and revise the treatment strategy if appropriate. Imaging findings should be correlated with physical findings. In general, an imaging study may be an appropriate consideration for a patient whose limitations due to consistent symptoms have persisted for 1 month or more, as in the following cases: 1) When surgery is being considered for a specific anatomic defect, 2) To further evaluate potentially serious pathology, such as a possible tumor, when the clinical examination suggests the diagnosis." A review of the submitted medical records documented that the employee had plain films X-rays on 5/22/13 that were normal. The 7/1/13 clinical exam findings of positive Valgus stress and Cozens, suggest epicondylitis or collateral ligament tear; however, the medical records do not document surgery is being considered and the clinical examination does not suggest tumor or potentially serious pathology. The request for an 3D MRI to the right elbow **is not medically necessary and appropriate.**

5) Regarding the request for a multi-interferential stimulator :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines Interferential Current Stimulation (ICS), pages 118-119, part of the MTUS. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines Interferential Current Stimulation (ICS), pages 118-119, part of the MTUS, as applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained an industrial related injury to the right elbow on 5/21/13. A review of the medical records submitted indicates treatments have included: physical therapy, cortisone injection, and return to work with modifications. A request was submitted for an EMG for left upper extremity, NCV for left upper extremity, a qualified functional capacity evaluation, 3D MRI to the right elbow, a multi-interferential stimulator and range of motion measurement.

The request does not meet the MTUS Chronic Pain guidelines criteria for a multi-interferential stimulator. There is no evidence in the records provided that the employee's pain is ineffectively controlled by medications due to diminished effectiveness of medications or medication side effects, or that the patient has a history of substance abuse. Additionally, there is no evidence of a 1-month trial. Therefore, the request for a multi-interferential stimulator **is not medically necessary and appropriate.**

6) Regarding the request for range of motion measurement :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Claims Administrator based its decision on the American Medical Association (AMA), Evaluation of Permanent Impairment, 5th edition, page 400, a Medical Treatment Guideline (MTG), not part of the MTUS. The Expert Reviewer found the Elbow Disorders Chapter (ACOEM Practice Guidelines, 2nd Edition (Revised 2007), Chapter 10), Physical Examination, pages 7-8, part of the MTUS, applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained an industrial related injury to the right elbow on 5/21/13. A review of the medical records submitted indicates treatments have included: physical therapy, cortisone injection, and return to work with modifications. A request was submitted for an EMG for left upper extremity, NCV for left upper extremity, a qualified functional capacity evaluation, 3D MRI to the right elbow, a multi-interferential stimulator and range of motion measurement.

MTUS/ACOEM guidelines state "elbow ROM (range of motion) is a normal part of the elbow examination". A review of the submitted medical records document that the employee had a right elbow ROM evaluation performed on 6/11/13, 6/18/13 and 7/1/13. There is no documentation in the records provided to support

the need for a ROM evaluation as a separate procedure. The request for a range of motion measurement **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

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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.