
Notice of Independent Medical Review Determination

Dated: 10/29/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/1/2013

4/20/2011

7/26/2013

CM13-0003938

- 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 right upper extremity **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for NCV left upper extremity **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for EMG right upper extremity **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/1/2013. 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 right upper extremity **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for NCV left upper extremity **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for EMG right upper extremity **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The expert reviewer 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 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 1, 2013:

“According to progress report dated 06/25/13 by [REDACTED] MD, the patient came in for evaluation due to chief complaint of bilateral wrist tendonitis, forearm tendonitis, status post bilateral carpal tunnel release. The patient continued to complain of pain and swelling to the wrist. The patient did not have electromyogram (EMG) nerve conduction studies performed. The patient continued to complain of constant mild pain and Intermittent swelling to the wrist. On exam of bilateral upper extremities, the patient had mild swelling over the dorsal left wrist radial aspect. Durkan's produced a burning sensation to the middle and ring fingers bilaterally. There were 2+ equal radial pulses present. Capillary refill was less than two seconds. Distal sensation was grossly intact to light touch. Well-healed surgical incisions were present. No erythema or ecchymosis present.”

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 7/26/13)
- Utilization Review Determination from [REDACTED] (dated 7/1/13)
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Forearm, Wrist, and Hand Complaints, pp. 271-273, 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 the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 4/20/2011, resulting in injury to the wrists and forearms. The medical records provided for review indicate treatments have included status post bilateral carpal tunnel release. The request is for EMG left upper extremity.

MTUS/ACOEM guidelines support the use of Electrodiagnostic Studies (EDS) to help differentiate between CTS and other conditions. The medical records provided for review did not contain documentation regarding the need for the bilateral upper extremity electrodiagnostic studies (EDS). It is unclear what the employee's symptoms or previous EDS results were before surgery. Without more information about the employee's clinical history and response to treatment the authorization for the requested EDS is not recommended. The request for EMG left upper extremity is not medically necessary and appropriate.

2) 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Forearm, Wrist, and Hand Complaints, pp. 271-273, which is part of the Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer found the

guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 4/20/2011, resulting in injury to the wrists and forearms. The medical records provided for review indicate treatments have included status post bilateral carpal tunnel release. The request is for NCV right upper extremity.

MTUS/ACOEM guidelines support the use of Electrodiagnostic Studies (EDS) to help differentiate between CTS and other conditions. The medical records provided for review did not contain documentation regarding the need for the bilateral upper extremity electrodiagnostic studies (EDS). It is unclear what the employee's symptoms or previous EDS results were before surgery. Without more information about the employee's clinical history and response to treatment the authorization for the requested EDS is not recommended. The request for NCV right upper extremity is not medically necessary and appropriate.

3) 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Forearm, Wrist, and Hand Complaints, pp. 271-273, 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 the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 4/20/2011, resulting in injury to the wrists and forearms. The medical records provided for review indicate treatments have included status post bilateral carpal tunnel release. The request is for NCV left upper extremity.

MTUS/ACOEM guidelines support the use of Electrodiagnostic Studies (EDS) to help differentiate between CTS and other conditions. The medical records provided for review did not contain documentation regarding the need for the bilateral upper extremity electrodiagnostic studies (EDS). It is unclear what the employee's symptoms or previous EDS results were before surgery. Without more information about the employee's clinical history and response to treatment the authorization for the requested EDS is not recommended. The request for NCV left upper extremity is not 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Forearm, Wrist, and Hand Complaints, pg. 271-273, 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 the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 4/20/2011, resulting in injury to the wrists and forearms. The medical records provided for review indicate treatments have included status post bilateral carpal tunnel release. The request is for EMG right upper extremity.

MTUS/ACOEM guidelines support the use of Electrodiagnostic Studies (EDS) to help differentiate between CTS and other conditions. The medical records provided for review did not contain documentation regarding the need for the bilateral upper extremity electrodiagnostic studies (EDS). It is unclear what the employee's symptoms or previous EDS results were before surgery. Without more information about the employee's clinical history and response to treatment the authorization for the requested EDS is not recommended. The request for EMG 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, 18th Floor
Oakland, CA 94612

/mbg

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.