

**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**

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Dated: 11/13/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/26/2013
Date of Injury:	7/29/2010
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0006245

- 1) MAXIMUS Federal Services, Inc. has determined the request for **EMG bilateral lower extremities is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **NCS bilateral lower extremities is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/26/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/27/2013. 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 bilateral lower extremities is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **NCS bilateral lower extremities 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 Neurology 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.

### Expert Reviewer Case Summary:

The patient is a 41 year old with chronic pain. He has had injuries dating back to 1995, with subsequent injuries since. There has been neck, shoulder and back pain, sciatica, prior epidurals, and spinal surgery. He has had prior EMG consistent with chronic left S1 radiculopathy, and has been left with a chronic pain syndrome despite therapy and medical management. Post laminectomy syndrome has been diagnosed. NCVs and EMG has been requested of the bilateral lower extremities.

### 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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for EMG bilateral lower extremities:**

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 Chronic Pain Medical Treatment Guidelines, Sections for Chronic Pain Management Programs and Medications for Chronic Pain. The Claims Administrator also based its decision on the Official Disability Guidelines(ODG), online version, Low Back-Electrodiagnostic Studies.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004) Low Back, Chapter 12 and table 12.4, 12.7, which are part of the MTUS, and the Official Disability Guidelines (ODG), Low Back, EMG, which is not part of the MTUS.

Rationale for the Decision:

ODG notes that EMG is not advised for clinically obvious radiculopathy, and is recommended to clarify nerve root dysfunction. The employee has chronic pain, for which clarification of level of nerve irritation will not change treatment options. The employee has had surgery and epidurals without benefit in the past. The employee has been diagnosed with post laminectomy syndrome. MTUS does not recommend EMG testing in this circumstance. Probability of success with further surgery is noted to be low in guidelines, stating that surgery benefits fewer than 40% of individuals with questionable physiologic findings. **The request for EMG bilateral lower extremities is not medically necessary and appropriate.**

**1) Regarding the request for NCS bilateral lower extremities:**

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 Chronic Pain Medical Treatment Guidelines, Sections for Chronic Pain Management Programs and Medications for Chronic Pain. The Claims Administrator also based its decision on the Official Disability Guidelines(ODG), online version, Low Back-Electrodiagnostic Studies.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004) Low Back, Chapter 12 and table 12.4, 12.7, which are part of the MTUS, and the Official Disability Guidelines (ODG), Low Back, NCV, which is not part of the MTUS.

Rationale for the Decision:

ODG Low Back notes that NCVs are not justified if an individual is presumed to have pain from radiculopathy. The clinical features and prior EMG are consistent with radiculopathy. **The request for NCS 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,

Paul Manchester, MD, MPH  
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.