

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/28/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/2/2013
Date of Injury: 5/1/2011
IMR Application Received: 8/7/2013
MAXIMUS Case Number: CM13-0008134

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. This means we decided that all of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The date of injury in this case is 05/01/2011. The patient's referenced diagnosis is lumbosacral radiculitis. The patient also has a diagnosis of low back pain, rule out intradiscal component, and right wrist/hand pain. On 07/02/2013, the patient was seen in followup consultation with symptoms including right wrist pain. An upper extremity neurological examination demonstrated positive Tinel's and Phalen's sign on the right, and the patient had diminished sensation in the median distribution on the right and a markedly limited Jamar grip. The patient was noted to have previously undergone electrodiagnostic testing in July 2012, which demonstrated profound changes including the presence of ulnar involvement and a progressive median neuropathy. On 08/08/2013, the treating provider expressed concern regarding a gradual crescendo right upper extremity neurological component with possible right carpal tunnel syndrome. An electrodiagnostic study was requested of the bilateral upper extremities. An initial physician review recommended certification of nerve conduction studies of the upper extremities but non-certification of EMG or electromyography, noting Official Disability Guidelines which states that electromyography is indicated only in cases where the diagnosis is difficult with nerve conduction studies.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. Outpatient EMG/NCV of the bilateral upper extremities is medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter, Electromyography, which is not part of MTUS.

The Physician Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), pg. 178, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS/ACOEM Guidelines indicate that Belectromyography and nerve conduction velocities (EMG/NCV) may help identify subtle focal neurological dysfunction in patients with neck or arm symptoms or both lasting more than 3 or 4 weeks. The guidelines therefore do support both nerve conduction studies and electromyography. The treating physician has reported what has been described as crescendo findings with worsening of both symptoms and neurological examination findings and a differential diagnosis involving both a peripheral neuropathy and a radiculopathy. Nerve conduction studies are required to assess for a possible focal peripheral neuropathy. However, a component of radiculopathy could only be determined with additional needle examination studies or electromyography. For this reason, the nerve conduction study and the electromyography are supported by the guidelines. **The request for outpatient EMG/NCV of the bilateral upper extremities is medically necessary and appropriate.**

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