

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/26/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/19/2013
Date of Injury: 9/27/2010
IMR Application Received: 8/6/2013
MAXIMUS Case Number: CM13-0008251

- 1) MAXIMUS Federal Services, Inc. has determined the request for **EMG/NCV bilateral upper extremities is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **functional capacity evaluation is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/6/2013 disputing the Utilization Review Denial dated 7/19/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/9/2013. 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/NCV bilateral upper extremities is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **functional capacity evaluation 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 Oklahoma. 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 58-year-old male who reported an injury on 04/16/2010. An operative report was submitted on 10/21/2011 by Dr. [REDACTED], which indicated that the patient underwent right shoulder diagnostic arthroscopy, extensive synovectomy, chondroplasty of the glenoid, right shoulder arthrotomy, open subacromial decompression and resection of the CA ligament, repair of the rotator cuff, injection with lidocaine for postop comfort, application of a brace, and placement of a pain pump through a separate incision. The patient was then seen by Dr. [REDACTED] on 02/11/2013 with complaints of right shoulder pain. Physical examination revealed chest wall tenderness, no evidence of edema, and intact peripheral pulses of the upper extremities. Treatment plan included discontinuation of all anti-inflammatory, herbal, and over the counter medications. The patient was again seen by Dr. [REDACTED] on 01/23/2013 with complaints of right-sided shoulder pain with weakness. It was noted at that time that authorization had been provided to proceed with a right shoulder surgical intervention. An additional operative report was submitted by Dr. [REDACTED] on 02/15/2013, which indicated that the patient underwent right shoulder diagnostic arthroscopy, extensive synovectomy, chondroplasty, revision of the arthroscopic subacromial decompression without resection, injection of lidocaine for postop comfort, placement of a brace, and open Mumford procedure. The patient followed up with Dr. [REDACTED] on 03/06/2013. The patient continued to complain of residual pain with weakness and loss of motion. It was recommended at that time that the patient begin aggressive rotator cuff strengthening with physical therapy modalities. The patient was again seen by Dr. [REDACTED] on 04/03/2013. The patient complained of significant left foot pain. Physical examination revealed continued loss of range of motion in flexion and abduction, very mild impingement and Hawkins' signs noted, 4/5 strength, and hyperesthesia of the left lower extremity with difficulty weight-bearing. Treatment plan

included an additional 12 sessions of postoperative physical therapy for the right shoulder. A Secondary Treating Physician Pain Management Initial Report was submitted by Dr. [REDACTED] on 04/16/2013. The patient presented with complaints of 5/10 to 6/10 right shoulder pain. Physical examination of the right shoulder was not provided at that time. Diagnoses included left foot contusion and status post right shoulder arthroscopic surgery. It is noted that the patient has completed physical therapy and acupuncture sessions with continued reports of pain. The patient was then provided with samples of Voltaren gel. The patient was then seen by Dr. [REDACTED] on 05/15/2013, 06/26/2013, and 07/19/2013. The patient continued to report 6/10 residual right shoulder pain. Physical examination revealed decreased range of motion of the right shoulder, 4/5 deltoid strength noted, and decreased range of motion in all planes of the right ankle as well. Treatment plan included a home exercise program, continuation of current medications, and options for physical and acupuncture therapy and durable medical equipment. A utilization review report was then submitted on 07/19/2013 by Ms. [REDACTED]. Specific treatments requested include an EMG/NCV study of bilateral upper extremities as well as a functional capacity evaluation. Both of the requested treatments were non-certified at that time.

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/NCV bilateral upper extremities:

Section of the Medical Treatment Utilization Schedule (MTUS) 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) Practice Guidelines, 2nd Edition, Neck and Upper Back Complaints, Chapter 8, page 178 and table 8-8, which is part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Low Back Chapter, Diagnostic Investigations, page 177-179, which is part of the MTUS.

Rationale for the Decision:

The California MTUS/ACOEM Practice Guidelines state that electrodiagnostic studies, which must include EMG, are recommended where a CT or MRI is equivocal and there are ongoing pain complaints that raise questions about whether there may be a neurological compromise that may be identifiable. Needle EMG studies usually make the diagnosis of radiculopathy or spinal stenosis in patients with back pain or radiculopathy problems; and, they can help

determine if radiculopathy is acute or chronic. Nerve conduction studies are usually normal in radiculopathy. The medical records provided for review indicate no evidence of a diagnosis of radiculopathy or neuropathic pain for this employee. There is no indication that this employee's chronic pain is neurological in origin. Therefore, an EMG/NCV study cannot be determined as appropriate at this time. **The request for EMG/NCV bilateral upper extremities is not medically necessary and appropriate.**

2) Regarding the request for functional capacity evaluation:

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

The Claims Administrator based its decision on the ACOEM Practice Guidelines, 2nd Edition, Independent Medical Examinations and Consultations, Chapter 7, pages 137-138, and the Official Disability Guidelines (ODG), which are not part of the MTUS.

The Expert Reviewer based his/her decision on the ACOEM, 2nd Edition, (2004), Chapter 5, Cornerstones of Disability Prevention and Management, pages 89-92 which are part of the MTUS.

Rationale for the Decision:

The CA MTUS/ACOEM Practice Guidelines state the first step in managing delayed recovery is to document the patient's current state of functional ability (including activities of daily living) and the recovery trajectory to date as a time line which can be determined by an FCE. The most recent surgical intervention was completed on 02/15/2013. Dr. [REDACTED] notes on 05/15/2013 that the employee still had not yet begun postoperative therapy following the second surgical intervention. The employee continues to complain of residual shoulder pain with decreased range of motion. There is no evidence suggesting that the employee has failed a trial of returning to work following each of these surgical interventions completed. During the latest office visit on 06/26/2013, the employee stated that the overall range of motion and functional capacity status had improved significantly postoperatively. There is no evidence of significant functional limitations that would warrant the need for a functional capacity evaluation at this time. **The request for functional capacity evaluation 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, 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.