

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

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**Notice of Independent Medical Review Determination**

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Dated: 11/12/2013

[REDACTED]

[REDACTED]

|                           |              |
|---------------------------|--------------|
| Employee:                 | [REDACTED]   |
| Claim Number:             | [REDACTED]   |
| Date of UR Decision:      | 8/1/2013     |
| Date of Injury:           | 7/29/2010    |
| IMR Application Received: | 8/7/2013     |
| MAXIMUS Case Number:      | CM13-0008293 |

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

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/7/2013 disputing the Utilization Review Denial dated 8/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/6/2013. 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 of the bilateral lower extremities is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **NCS of the 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 has reported chronic pain with prior lumbar surgery x 2, with diagnosis of post laminectomy syndrome, degenerative disc disease L4-5, L5-S1, lumbar stenosis, left ankle sprain, and chronic pain syndrome. Pain management efforts have been ongoing, including medications, cognitive behavioral therapy, as well as prior injection procedures. MRI has in the past shown disc bulges and nerve root impingement, left S1. Examination reports motor decreased left L5, and sensation decreased left L5-S1. No additional spine surgery is planned. Bilateral NCV/EMG has been requested to rule out radiculopathy vs neuropathy.

### **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 of the 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 the Official Disability Guidelines, Low Back, Electrodiagnostic Studies, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12), Table 12.4, 12.7, which is part of the MTUS and ODG-Low Back Chapter, which is not a part of the MTUS.

Rationale for the Decision:

After a review of the medical records provided, this employee has chronic pain with diagnosed radicular features. ACOEM notes that EMG is indicated for disk protrusion and can be useful to identify subtle neurologic dysfunction. ODG notes that EMG is not advised for EMG for clinically obvious radiculopathy, and is recommended to clarify nerve root dysfunction. This employee has had diagnosis of disc protrusion and clinically obvious radicular findings, for which EMG is not advised. **The request for an EMG of the bilateral lower extremities is not medically necessary and appropriate.**

**2) Regarding the request for NCS of the 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 the Official Disability Guidelines, Low Back, Electrodiagnostic Studies, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12), Table 12.4, 12.7, which is part of the MTUS.

Rationale for the Decision:

NCVs are not recommended for low back conditions. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. After a review of the medical records provided, there are no clinical features that suggest neuropathy, for which NCV studies may be useful. **The request for the NCS of the bilateral lower extremities 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.