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## Independent Medical Review Final Determination Letter

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Dated: 12/26/2013

<b>IMR Case Number:</b>	CM13-0011127	<b>Date of Injury:</b>	6/30/2009
<b>Claims Number:</b>	██████████	<b>UR Denial Date:</b>	7/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	8/8/2013
<b>Employee Name:</b>	██████████ ██████████		
<b>Provider Name:</b>	████████████████████		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>	Please reference utilization review determination letter		

DEAR ██████████

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: UPHOLD. This means we decided that none 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, ██████████

## 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 Family Practice and is licensed to practice in Texas. 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 patient is a 62-year-old male who reported an injury on 06/30/2009 with the mechanism of injury being a trip and fall. The patient was noted to have continued complaints of pain in the right shoulder with numbness and tingling to the index and small finger of the right hand. The patient was noted to have diminished sensation at C6 and C7, and reflexes were noted to be 2+. Diagnoses were stated to include cervical radiculitis, bilateral upper extremities, C6 and C7 nerve root distributions and degenerative disc disease of the cervical spine. The treatment plan was noted to include Prilosec and an EMG/NCV of the bilateral upper extremities.

### IMR DECISION(S) AND RATIONALE(S)

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

#### **1. Unknown prescription of Prilosec is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009), which are part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 69-70, which are part of the MTUS.

The Physician Reviewer's decision rationale:

The California MTUS Guidelines recommend treatment of dyspepsia secondary to NSAID therapy with a PPI. The clinical documentation submitted for review indicated that the physician was asking for Prilosec based on the patient's longstanding use of NSAID medications. The clinical documentation, however, failed to provide that the patient had signs and symptoms to support the use of Prilosec and failed to provide the efficacy of the medication. Additionally, it failed to provide the duration of care as well as the strength of the requested medication. The

request for an unknown prescription of Prilosec is not medically necessary and is not medically appropriate.

## **2. 1 EMG/NCS of the bilateral upper extremity is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009), which are part of the MTUS.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 8, page 182, which is part of the MTUS.

The Physician Reviewer's decision rationale:

ACOEM Guidelines recommend an EMG for cervical nerve root compression with radiculopathy for patients to clarify nerve root dysfunction in cases of suspected disc herniation preoperatively or before an epidural injection and when the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The clinical documentation submitted for review indicated that the physician would like an EMG of the bilateral upper extremities to evaluate the patient's radicular complaints. The physical examination revealed that the patient had diminished sensation at C6-7 and had motor testing of 4/5 to all muscle groups in the upper extremities and had complaints of numbness and tingling to the index and small fingers on the right hand. The clinical documentation submitted for review indicated that the patient had cervical radiculopathy and therefore failed to support the need for an EMG. ACOEM guidelines indicate the Nerve conduction velocity tests may help to identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms; however, the clinical documentation submitted for review indicated that the patient had positive findings to support the diagnosis of radiculopathy and therefore failed to necessitate a secondary test. Additionally, it was noted the request was for bilateral testing and there was a lack of documentation indicating the necessity for bilateral testing. Given the above, the 1 EMG/NCS of the bilateral upper extremities is not medically necessary and is not medically appropriate.

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.

[REDACTED]

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