

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



---

**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/26/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/12/2013  
Date of Injury: 6/4/2012  
IMR Application Received: 7/22/2013  
MAXIMUS Case Number: CM13-0002466

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: 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, [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 Neurologist, has a subspecialty in Fellowship trained in Neuro-Oncology 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 patient is a 47 year old male who reported an injury on 02/07/2011-02/07/2012. The patient has right shoulder pain radiating to his hand with occasional paresthesias and pain into the right elbow. It is noted that he has full range of motion in the shoulder. He had shoulder arthroscopy on 02/19/2013, followed by postoperative physical therapy. His diagnoses include shoulder pain, infraspinatus sprain/strain, supraspinatus sprain/strain, and lesion of ulnar nerve.

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

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

**1. Electromyography and nerve conduction velocity studies, of the right upper extremity is not medically necessary and appropriate.**

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine, Hand and Wrist disorders, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Elbow Disorders Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (Revised 2007), Chapter 10) pages 42-43, which is part of the MTUS.

The Physician Reviewer's decision rationale:

At on office visit on 06/21/2013 with [REDACTED], PA. The patient reported increased right elbow pain and numbness. The physical exam noted a positive Tinel's sign and poor 2 point discrimination along ulnar nerve dermatome, > 6mm. It was noted in the provided medical records that this finding is consistent with cubital tunnel syndrome. The CA MTUS/ACOEM Guidelines indicate electromyography (EMG) study is indicated if cervical radiculopathy is

suspected as a cause of lateral arm pain, and that condition has been present for at least 6 weeks. CA MTUS/ACOEM Guidelines further state a nerve conduction study and possibly EMG is supported if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is failure to respond to conservative treatment. The patient does have documented objective findings consistent with cubital tunnel syndrome which would support performing nerve conduction studies; however, the clinical information submitted did not provide a rationale for performing the electromyography in conjunction with the nerve conduction study. Therefore, the request for electromyography and nerve conduction velocity studies, of the right upper extremity is not medically necessary.

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]  
[REDACTED]  
[REDACTED]

CM13-0002466