

<b>Case Number:</b>	CM14-0137611		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	09/10/2013
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	07/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Emergency Medicine 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 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

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

The injured worker is a 45-year-old male who reported an injury on 09/10/2013. The mechanism of injury was due to a fall while pulling netting from grapevines, fell back, and landed on his buttocks. The injured worker has diagnoses of left hip greater trochanteric bursitis, left hip osteoarthritis, and lumbar radiculopathy. Past medical treatment consists of physical therapy, the use of a TENS unit, acupuncture, and medication therapy. Medications include Norco, Nortriptyline, and Prilosec. The injured worker underwent an x-ray of the left hip on 06/20/2014, MRI of the left hip on 07/24/2014, and an EMG/NCV on 07/02/2014. On 08/14/2014, the injured worker complained of pain in the left hip. Physical examination revealed that there was tenderness to palpation over the greater trochanter. There was no pain with range of motion. Range of motion consisted of a flexion of 120 degrees, extension of 30 degrees, abduction of 45 degrees, adduction of 30 degrees, external rotation of 50 degrees, and internal rotation of 40 degrees. The Trendelenburg sign was negative and FABERE test was positive. The medical treatment plan is for the injured worker to undergo bilateral upper extremity EMG and bilateral upper extremity NCS. The rationale and Request for Authorization form were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Upper Extremity EMG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** TThe request for Bilateral Upper Extremity EMG is not medically necessary. The California MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocity studies, including H reflex tests, may help identify subtle, focal, neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 or 4 weeks. The submitted report dated 08/14/2014 did not indicate that the injured worker was having any cervical pain or upper back pain. Additionally, the submitted report did not indicate that there were any neurological deficits pertaining to the cervical spine or upper back. There was also no evidence of decreased reflexes, decreased strength, or decreased sensation. An adequate examination of the injured worker as not provided detailing current deficits to warrant an EMG of the upper extremity. As such, the request for Bilateral Upper Extremity EMG is not medically necessary.

**Bilateral Upper Extremity NCS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The request for Bilateral Upper Extremity NCS is not medically necessary. The California MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocity studies, including H reflex tests, may help identify subtle, focal, neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 or 4 weeks. The submitted report dated 08/14/2014 did not indicate that the injured worker was having any cervical pain or upper back pain. Additionally, the submitted report did not indicate that there were any neurological deficits pertaining to the cervical spine or upper back. There was also no evidence of decreased reflexes, decreased strength, or decreased sensation. An adequate examination of the injured worker as not provided detailing current deficits to warrant an EMG of the upper extremity. As such, the request for Bilateral Upper Extremity NCS is not medically necessary.