

<b>Case Number:</b>	CM14-0193399		
<b>Date Assigned:</b>	12/01/2014	<b>Date of Injury:</b>	08/30/2011
<b>Decision Date:</b>	01/13/2015	<b>UR Denial Date:</b>	10/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2014

### 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 Internal Medicine 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 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 (IW) is a 63-year-old man with a date of injury of August 30, 2011. The mechanism of injury occurred as the IW was moving a steel plate while working as a deputy inspector. The IW felt pain in his right thumb. The IW has been diagnosed with right median neuropathy, carpal tunnel, right thumb stenosing tenosynovitis, right De Quervain's disease, right basal joint arthritis, early and mild; and right ring finger tendinitis without triggering. The injured worker's treatment has included medications, occupational therapy, acupuncture, bracing, and splinting. MRI of the right wrist dated August 7, 2014 revealed a mild amount of fluid seen within the ulnocarpal and radiocarpal joints surrounding the triangular fibrocartilage complex. MRI of the right hand on August 7, 2013 revealed a focal area of increased signal well defines within the proximal portion of the proximal phalanx of the 4th finger measuring 1.8 X 0.9 cm that could represent benign cystic lesion. Pursuant to the Initial Orthopedic Hand Surgery Specialist Consultation dated September 11, 2014, the IW has been working modified duty and complains of continued pain at the base of the right thumb and wrist. He has occasional numbness of the right thumb, limited range of motion of the right thumb, occasional pain in the right wrist, weakness of the right wrist, and difficulties with gripping and grasping with the right hand. Physical exam was normal with the exception for positive Finkelstein's test on the right wrist, moderate tenderness to the right thenar eminence, and slight tenderness with subluxation of the right basal joint. There is joint tenderness to direct palpation of the A-1 pulley right thumb, positive grind test and first carpometacarpal (CMC) joint. The treating physician noted bilateral x-rays would be absolutely required so that the injured side versus normal non-injured side can be compared directly. The treating physician is requesting authorization for consult and treat plan by a neurologist.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Consult and Treatment plan by a Neurologist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines Chapter 7, Independent Medical Examination and Consultations page 127

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Independent Medical Examinations, Page 127 Official Disability Guidelines (ODG); Forearm, Wrists and Hands, Carpal Tunnel Syndrome, NCV/EMG

**Decision rationale:** Pursuant to the ACOEM and the Official Disability Guidelines, consultation and treatment by neurologist are not medically necessary. The guidelines state an occupational health practitioner may refer to other specialists if the diagnosis is uncertain or extremely complex, when psychosocial factors are present, when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability of the examinee's fitness for return to work. Nerve conduction velocity studies are indicated in patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery. Carpal tunnel syndrome must be proved by positive findings on clinical examination. Electromyography (EMG) is recommended only in cases where the diagnosis is difficult to establish with nerve conduction velocity studies. In this case, the injured worker is a 63-year-old man with a date of injury August 30, 2011. The working diagnoses are right median neuropathy, carpal tunnel, right thumb stenosing tenosynovitis, right De Quervain's disease, right basal joint arthritis, early and mild right ring finger tendinitis without triggering. Treatment has consisted of occupational therapy, acupuncture, bracing, splinting and medication. MRI of right wrist showed mild amount of fluid within the ulnocarpal and radiocarpal joints. The treating physician recommended a consultation and treatment plan by a neurologist for EMG/nerve conduction velocity studies bilateral upper extremities including SSEP of the ulna and median nerves. These tests are indicated for generalized analysis of the somatosensory nervous system, to determine a response based upon sensory stimulation and to obtain additional information regarding the possible dysfunction at the level of peripheral nerve, brachial plexus, cervical spine and spinal cord. Although the nerve conduction velocity study is appropriate to rule out carpal tunnel syndrome, there is no indication for an electromyogram or somatosensory evoked potentials (SSEP) because there were no subjective complaints or objective physical findings of ulna nerve neuropathy. There were no clinical findings suggestive of nerve root compromise and cervical spine. The number of tests performed should be the minimum needed to establish an accurate diagnosis. Authorization for both nerve conduction velocity studies and the request for a consultation and treatment plan by a neurologist is a duplicate service. The neurology consult and treatment plan is unnecessary, however, the nerve conduction velocity study is medically necessary. Consequently, Consultation and a Treatment Plan by a Neurologist are not medically necessary.