

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-03-3992.M2**

June 18, 2003

MDR Tracking #: M2-03-1208-01

IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Neurology. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was a 50-year-old woman at the time of her injury that occurred on ___. She was working as a reservation agent for ___ and started developing pain in her neck and shoulders with numbness and tingling in her hand. She also complained of weakness in her hand. ___ did a thorough medical evaluation on August 21, 201; this was approximately one month after her reported symptoms at work. His additional history stated that her hands and arms were weak and numb constantly, but sometimes worse at night. His examination at that time showed good range of motion of the upper extremities, sensation was decreased to pin prick and light touch in the right thumb and positive tinels on the right. There was also some tenderness in the cervical paraspinal and shoulder muscles. The EMG study and nerve conduction studies were done of both upper extremities and cervical paraspinal muscles. This was a detailed examination and the only abnormality that was determined was that there was as prolonged latency of the right median sensory nerve. The impression was, at that time, that there was mild right carpal tunnel syndrome of the right hand. There was no evidence electrically of a cervical radiculopathy and no definite evidence of carpal tunnel symptoms of the left side.

There are medical records from ___ who had seen her during a good portion of her illness. He saw her on March 14, 2002. She had had carpal tunnel surgery on the right side at that time, just two weeks before he saw her. She continued to have neck and shoulder pain. The cervical spine x-ray at that time showed some minimal degenerative changes at C3 to C5. His examination of the upper and lower extremities showed normal reflexes. There was some mild weakness of the

median nerve distribution muscles on the left and less so on the right. The neck showed tenderness and some spasm in the cervical muscles. It was his impression that the patient had bilateral carpal syndrome with most recent surgery done on the right and chronic cervical strain. He recommended continued physical therapy and medication to include Prozac and Baclofen.

___ saw her again on January 8, 2002. He gave her trigger-point injections at that time to the neck and shoulders; he gave her neck and stretching exercises and continued physical therapy to her neck and shoulders. On August 20, 2002 ___ saw her again and this time did a detailed EMG study of her upper extremities, and at this time he did median and ulnar motor and sensory nerves of both arms, hands and all the muscles of the upper extremity. At this time, he did not find any evidence of any carpal tunnel entrapment electrically or any other abnormality. Of note is that ___ had had carpal tunnel surgery on that side six months prior to that EMG that was done by ___ on August 20, 2002.

___ saw her on October 3, 2002. He stated that the patient was having a lot of trouble with her left hand. She had three injections into the right carpal tunnel on the right side with some improvement, but she had more symptoms on the left. He made a comment that he believed that the carpal tunnel was there, even when the EMG study was negative. Her chiropractor, ___, saw her on April 10, 2002 and during her illness she was six-weeks post right carpal tunnel surgery and was making good progress, but was still having neck pain. She was having more neck and shoulder pain and arm pain on the left. His examination showed a scar from the right carpal tunnel surgery with no complications, positive tinels on the left and weakness of the small muscles of the hand on the left. It was recommended that the patient go through some more rehabilitation and physical therapy. There is a 2003 evaluation ___, who saw her on March 27, 2003. She stated that she was having some pain and numbness in the ulnar nerve distribution. Her little finger would become numb on flexion of the wrist. He thought there was a possible problem with the ulnar nerve on the left, since the release had been done on the left side in the past. As a result, he wanted to do a repeat EMG to rule out a cubital tunnel syndrome.

REQUESTED SERVICE

A repeat EMG/NCV study of the bilateral upper extremities is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

___ sustained a work-related injury on ___ and has had and continues to have numerous complaints of neck and shoulder pain within intermittent numbness of her hand. She had two extensive EMG studies in 2001 and also in 2002. The first one in 2001 did show some mild carpal tunnel on the right, but the study in 2002 did not. The patient had both carpal tunnel regions operated on and had been apparently making some improvement, though during her whole illness she continues to have numbness in her hands, forearms, neck and shoulder discomfort. The reviewer does not find that there is any electrical or clinical evidence for a cervical radiculopathy. The reviewer is aware, upon review of these records, that this patient

improved after the carpal tunnel surgery, even though the more recent EMG studies did not show any abnormality. It is well known that anywhere from five to ten percent of patients can have good carpal tunnel symptoms in the absence of an EMG abnormality. This is so in this case, since surgery had been fairly successful in treating her symptoms.

Her current symptoms of some tingling in the left little finger, however, is not very specific. There does not appear to be any evidence from reviewing the detailed records of her physicians that she indeed has any definite evidence for any abnormality of ulnar nerve distribution. The previous two EMGs did not reveal any evidence of ulnar nerve problems and entrapment. It is not stated in any of the EMGs that the cubital tunnel was specifically evaluated, but there was no evidence of any sensory ulnar or across the elbow slowing of the ulnar nerves on the previous two EMGs. The reviewer believes that the likelihood of doing further studies on the vague clinical hunch that this is a cubital tunnel compression syndrome, without any definite objective findings on examination, makes for a very low probability that any positive results will be obtained.

As a result, because of the extensive EMGs that have been done on this patient now for 2001 and 2002, and because of the very nonspecific symptoms that she has, the reviewer finds that a repeat EMG study is not indicated at this time for her left hand or for any of her symptoms that have been outlined in her medical record.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings,

Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).