

May 24, 2004

MDR Tracking #: M2-04-1282-01

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 board certified and specialized in Neurology. The reviewer is on the TWCC Approved Doctor List (ADL). 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

The records begin with \_\_\_ seeing \_\_\_, neurosurgeon, on August 14, 2000. He stated in his note that the patient was a transcriptionist who began having severe pain in the left wrist on \_\_\_. At that time she was given medication, rehabilitation and wrist splints. She was diagnosed at that time with carpal tunnel syndrome. He stated that she only had symptoms on the left hand at that time and none on the right. The day of examination was August 14, 2000 she was having bilateral pain to both wrists, more left than right.

He had reviewed an MRI of her neck that had been done in the recent past, and it was normal. His examination, at that time, stated that her hands were clinically normal except there was some subjective tingling in both hands. He did not find any motor weakness and no comments were made about her sensory examination. He suggested that the patient undergo EMG studies and nerve conduction of the right hand and he wanted to see her back in two weeks. He felt that the diagnosis was left carpal tunnel and likely right carpal tunnel syndrome. The patient underwent an EMG study by the same physician on August 31, 2000. The examination studies the right median motor and sensory and the needle exam involved the right upper extremity but did not include any of the muscles of the hand. The right median distal motor latency was 4.52 msec with a normal nerve conduction velocity and the right median distal latency was 3.48 msec, which is normal but the right medial palmar latency was 2.4 msec, which is prolonged.

The impression of that study was that the patient has a carpal tunnel syndrome of the right side. Also, he examined the right ulnar nerve, which showed a nerve conduction velocity below the elbow of 50 meters per second and 43 meters per second above the elbow. The digital sensory conduction was normal in the right ulnar nerve. He also concluded that the patient had an ulnar neuropathy across the elbow. Again, no needle examination was done on the right hand or any of the muscles innervated by the ulnar nerve.

The patient was seen again by \_\_\_ on September 11, 2000. He felt that based on the EMG and clinical examination that she now had a right carpal tunnel syndrome. He suggested that she wear bilateral wrist splints. His examination was unchanged and he recommended a left carpal tunnel release.

The patient returned to see him on October 6, 2000. She was post-op left carpal tunnel release and was healing nicely. His neurologic exam found that there were no changes, but no details were mentioned. He recommended that she start exercise of her left wrist.

\_\_\_ saw the same physician on October 31, 2000. At that time she was complaining of coldness and pain in her right arm and elbow. She still had numbness in the left hand. His examination showed right carpal tunnel and left hand post-carpal tunnel surgery. He suggested Tylenol III and Neruontin and wanted to see her again in a month for possible right carpal tunnel surgery. He was planning to operate on her right wrist on November 9, 2000 for right carpal tunnel syndrome. On December 5, 2000 the same physician saw the patient again and she was still continuing to have some numbness in the right and left hands. The examination was unchanged. He recommended Tylenol III and Neurontin 300 mg three times a day. On January 5, 2001 he saw the patient again. She was still complaining of numbness in both hands and also complained of pain in her left elbow. She was not working and was exercising at home. He recommended that she continue Neurontin three times a day.

There were no further notes until June 9, 2003 when \_\_\_ saw \_\_\_ again. She was still complaining of numbness in both hands. Even though she experienced carpal relief on September 14, 2000, the symptoms began to return. She started noticing symptoms in both hands. His examination showed normal reflexes in both upper and lower extremities with no weakness, no muscle atrophy, but positive Tinels signs in both hands. He suggested an anti-inflammatory medication and Neurontin. He recommended further nerve conduction studies of both hands at that time. There was a further EMG done on July 31, 2003. The right median conduction was normal with a distal motor latency of 4.32 msec. The right ulnar conduction still showed some suggestive slowing above the right elbow. The left median conduction was normal with a distal motor latency of 5.8 msec. The left ulnar nerve showed also some similar slowing across the left elbow. The right median sensory responses of the median nerve showed only a prolonged palmar sensory response of 2.52 msec. The digital index finger response was normal. The right

ulnar sensory response was normal. The left median digital response was normal but the left palmar response was prolonged. The left ulnar sensory response was normal.

Needle electrode examination was done again but this one predominately on the right side and once again only involved the cervical muscles and the proximal right upper extremity muscles. There was no testing on a needle examination of the forearm or hand muscles.

\_\_\_ again saw \_\_\_ on October 5, 2003. He stated in his letter that the patient was still having numbness of both hands. Her examination showed no weakness in the upper extremities and no abnormal reflexes. The only findings were positive Tinels sign in both hands. He was aware that the EMG study showed bilateral carpal tunnel syndrome greater on the left. He felt that the left side was residual carpal tunnel from previous surgery. He recommended the same medication and asked to see her in three months. He saw her again in February of 2004. The patient was working regularly but still was having pain in the right wrist and right hand. Her examination again was unremarkable in both upper and lower extremities without any sensory loss, muscle weakness or muscle atrophy. The rest of her evaluation was unremarkable.

He recommended that she continue her medication for pain, which is anti-inflammatory and also Neurontin, and asked to see her in three months.

She saw the same physician again on March 8, 2004. He stated that she was still having the same symptoms, but somewhat worse. The pain shoots from her hand to her elbow. She has intermittent numbness of the right hand and sometimes weakness when she tries to grab a cup of coffee. Her examination was unremarkable except for a Tinels sign at the right wrist. He suggested another nerve conduction study of her upper extremities and was concerned about an ulnar neuropathy that might be causing her symptoms at that time. He was also concerned that her symptoms of her carpal tunnel may be worse. He suggested a repeat EMG study at that time. The same physician wrote a letter to the insurance company on March 22, 2004 after the EMG test was denied and he felt that the test should be done because he was worried about residual carpal tunnel syndrome and possible ulnar neuropathy at the elbow. The patient saw the doctor again on March 22, 2004. He stated that the patient was having more symptoms in her hands and requested to the insurance carrier that the EMG be repeated.

#### REQUESTED SERVICE

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

#### DECISION

The reviewer agrees with the prior adverse determination.

### BASIS FOR THE DECISION

It is very clear from the medical records that this patient has symptoms of bilateral carpal tunnel syndrome as evident on all of the EMGs that have been done, including the one performed in July of 2003. She has already had surgery of the left hand in 2000, but it is not clear from the records whether or not she had surgery of the right hand. It is also clear from the EMG reports that at no time has there been any needle electrode examination of the forearms or hands, where predominately the symptoms occur. There does not appear to be any question that this patient clinically and on nerve conduction studies has carpal tunnel syndrome, but again, since the studies are incomplete with regards to needle electrode examination, nothing can be stated with reference to axonal damage to the median nerve distribution in either hand. \_\_\_ is concerned about an ulnar neuropathy where the description of a possible ulnar neuropathy is not present in his medical records. There is no comment made specifically about sensory loss in the ulnar distribution or weakness in the ulnar distribution or even any classic symptoms of ulnar neuropathy. The previous EMGs also show that the ulnar sensory responses and motor responses were normal and there is some slowing of the ulnar nerve above the elbow. This slowing in itself is not indicative of an ulnar neuropathy, since it usually does not become very significant clinically until there is a difference of ten meters per second between the nerve conduction of the ulnar nerve below the elbow and above the elbow. Once again, there was no needle examination done to examine any of the ulnar-innervated muscles in either hand at any time from these records. As a result, the reviewer does not find that the EMG study requested by \_\_\_ is going to be of any clinical value in this patient because the previous EMGs were incomplete and also because this patient clearly already has carpal tunnel syndrome. The \_\_\_ reviewer has found no evidence in the records that this right carpal tunnel syndrome had been operated on. It does not appear based on the previous EMGs that this patient has another underlying condition such as a peripheral neuropathy since the overall nerve conduction and sensory responses were relatively unremarkable for a peripheral neuropathy.

\_\_\_ 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 \_\_\_, 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 medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 24<sup>th</sup> day of May 2004.**