

Case Number:	CM14-0140039		
Date Assigned:	09/08/2014	Date of Injury:	10/02/2012
Decision Date:	11/20/2014	UR Denial Date:	08/04/2014
Priority:	Standard	Application Received:	08/29/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 53 year old female who had a work injury dated 10/2/12. The diagnoses include Lumbosacral spine musculoligamentous strain/sprain; right shoulder impingement syndrome; right elbow medial epicondylitis; bilateral carpal tunnel syndrome, history of right carpal tunnel release on an industrial basis, early 1990's, with disability award; right medial and lateral meniscal tears; left medial meniscus tear; bilateral knee osteoarthritis. Under consideration are requests for Prilosec 20mg #30 and EMG right upper extremities EMG left upper extremities. A 7/16/14 PR-2 report which is handwritten and mostly illegible states that the patient has persistent bilateral knee pain with popping/locking. Pain rated 7-8/10, constant, dull, sharp, cramping, burning, numbness, weakness, aching and soreness. The patient has bilateral wrist pain. On exam there is swelling. Medial (+) crepitus. There is a positive Tinel's sign at the median nerve. A prior 2012 electrodiagnostic study revealed moderate right carpal tunnel syndrome and mild left carpal tunnel syndrome. There is decreased wrist range of motion. There is an old scar at the right wrist. Plan: 1. Ortho consult for bilateral knees; urine drug screen; Norco; Prilosec; Anaprox and EMG/NCV bilateral upper extremities. The documentation indicates that the patient is now interested in pursuing carpal tunnel release. Documentation indicates that the patient underwent right carpal tunnel release in Dec. 1992. Per this patient previously underwent EMG/NCS testing of BUE (June 2012) that demonstrated moderate bilateral carpal tunnel syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines states that the patient is at risk for gastrointestinal events if they meet the following criteria (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The guidelines also state that a proton pump inhibitor can be considered if the patient has NSAID induced dyspepsia. The documentation does not indicate that the patient meets the criteria for a proton pump inhibitor and discontinued the NSAID Anaprox on documentation dated 7/16/14. The request therefore for Prilosec 20mg #30 is not medically necessary.

EMG right upper extremities: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Carpal Tunnel Syndrome

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261; 270. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Dumutru, Daneil and Zwarts, Machial. "Chapter 24 Focal Peripheral Neuropathies." *Electrodiagnostic Medicine*. By Daniel Dumitru. Philadelphia: Hanley & Belfus, 2002. 1066-1069. Print ; *Plast Reconstr Surg*. 2012 Mar;129(3):683-92. doi: 10.1097/PRS.0b013e3182402c37. Revision surgery for persistent and recurrent carpal tunnel syndrome and for failed carpal tunnel release. Jones NF1, Ahn HC, Eo S

Decision rationale: The MTUS ACOEM guidelines state that appropriate electrodiagnostic studies (EDS) may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome). Likewise, diabetic patients with peripheral neuropathy cannot expect full recovery and total abatement of symptoms after nerve decompression. The documentation indicates that the patient is status post right carpal tunnel release in 1992 and still has symptoms in the median distribution of the hand despite having undergone surgery. Per documentation an EMG/NCS done in 2012 continued to reveal carpal tunnel syndrome. According to Daniel Dumitru in the text *Electrodiagnostic Medicine* some patients continue to display altered neural conduction studies despite having surgery. If latency across the carpal tunnel is present the delay may be from recurrent median neuropathy; residual from prior neuropathy or a combination. The patient history, physical examination, and electrophysiologic findings must be combined to make an educated diagnostic opinion. Dumitru

furthermore states that the value of needle examination in patients with carpal tunnel syndrome is detecting additional lesions at a proximal level that may be coexistent with carpal tunnel syndrome. In particular a C6-C7 radiculopathy may be present. Up to 11% of patients with carpal tunnel syndrome have a concomitant double crush syndrome. Furthermore, the text states that it is not uncommon for a patient to have their carpal tunnel treated only to have continued symptoms in the appropriate hand. This may prompt unnecessary surgery. The needle EMG is capable of diagnosing both carpal tunnel syndrome and a cervical radiculopathy. Additionally, a review of surgical literature reveals that only a small number of patients present with recurrent symptoms. The documentation indicates that the patient has had carpal tunnel release and continues to have symptoms. Nerve conduction studies of the bilateral upper extremities were approved. It would be prudent prior to having a surgical intervention again to ensure that there are no additional conditions causing the patient's symptoms with complete Electrodiagnostic testing including not just the nerve conduction studies alone but the EMG study as well. Therefore, EMG of the Right Upper Extremity is medically necessary.

EMG left upper extremities: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Carpal Tunnel Syndrome

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261; 270. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Dumutru, Daneil and Zwarts, Machial. "Chapter 24 Focal Peripheral Neuropathies." *Electrodiagnostic Medicine*. By Daniel Dumitru. Philadelphia: Hanley & Belfus, 2002. 1066-1069; *Plast Reconstr Surg*. 2012 Mar;129(3):683-92. doi: 10.1097/PRS.0b013e3182402c37. Revision surgery for persistent and recurrent carpal tunnel syndrome and for failed carpal tunnel release. Jones NF1, Ahn HC, Eo S.

Decision rationale: The MTUS ACOEM guidelines state that appropriate electrodiagnostic studies (EDS) may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome). Likewise, diabetic patients with peripheral neuropathy cannot expect full recovery and total abatement of symptoms after nerve decompression. The documentation indicates that the patient is status post right carpal tunnel release in 1992 and still has symptoms in the median distribution of the right hand despite having undergone surgery and has left hand symptoms as well. Per documentation an EMG/NCS done in 2012 revealed bilateral carpal tunnel syndrome. According to Daniel Dumitru in the text *Electrodiagnostic Medicine* the value of needle examination in patients with carpal tunnel syndrome is detecting additional lesions at a proximal level that may be coexistent with carpal tunnel syndrome. In particular a C6-C7 radiculopathy may be present. Up to 11% of patients with carpal tunnel syndrome have a concomitant double crush syndrome.. The needle EMG is capable of diagnosing both carpal tunnel syndrome and a cervical radiculopathy. Nerve conduction studies of the bilateral upper extremities were approved. It would be prudent prior to having a surgical intervention for carpal tunnel syndrome to ensure that there are no additional conditions causing the patient's symptoms. This is especially important considering the patient

did not get full relief after surgery at the right carpal tunnel and the literature states it is not common for carpal tunnel to recur. This could be best evaluated with complete Electrodiagnostic testing including nerve conduction studies in combination with EMG. Therefore, EMG of the Left Upper Extremity is medically necessary.