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Notice of Independent Review Decision

DATE OF REVIEW: 12/22/2008

IRO CASE #:

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This case was reviewed by a Orthopaedic Surgery, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left wrist endoscopic CTR

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o December 15, 2008 chart note from , M.D.
- o November 10, 2008 utilization review report from
- o November 21, 2008 utilization review report from

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient is a xx year-old female who sustained an industrial injury on xx/xx/xx. According to chart notes, dated December 15, 2008, the patient's primary complaint is moderate pain of the left forearm, wrist, thumb, index finger, and long finger. She is noted to be right hand dominant. Symptoms also include numbness, tingling, weakness, and radiation. She has been previously treated with splinting/casting, hand therapy, a corticosteroid injection, surgery, work modifications, NSAIDs, and EMG. She remains off of work after an injection and a trial with Elavil. An EMG reportedly shows median nerve compression and correlates with her symptoms.

Examination findings included improved left dorsal arm sensitivity; healed scars; weak grip; continuation of shooting pain from the forearm into the hand; positive Tinel's over the median nerve; and positive compression test over the median nerve. She reports light touch to 3.61 to the left thumb, index finger, and long finger, and 2.83 to the ring finger and small finger. The physician recommended carpal tunnel release as the injection and braces have not been highly successful. The report notes that Elavil does not relieve all of her symptoms but makes her sleepy. She has failed therapy, braces, injections, work restrictions, and medications.

The records include a November 10, 2008 utilization review report which rendered a non-certification for this request. The report states that the patient is 17 months post-injury and subsequent excision of ganglion of the left wrist with release of the first dorsal compartment. Initial electrodiagnostic studies in July 2007 did not show neuropathy or radiculopathy. In May 2008, the patient was deemed at maximum medical improvement. More recently, she has been evaluated for weakness, numbness, and tingling of the left upper extremity. The physician referenced electrodiagnostic studies showing slowing across the carpal tunnel, but it was not clear to the reviewer whether this was in reference to the July 2007 study or a recent study. The report was not provided in the records for the peer-review physician. The reviewer noted that it is not clear from the records how long the claimant has been

symptomatic and how long she has tried conservative treatment. The Official Disability Guidelines require one month of conservative treatment. Given this information, a non-certification was rendered.

The case was again reviewed by another peer review doctor and another non-certification was provided on November 21, 2008. This report states that the patient had undergone physical therapy with no relief. The claimant does not have diabetes or thyroid disorders. The report noted that a prior designated doctor examination noted the claimant to be five foot three and weigh 145 pounds. Her body habitus and possible weight change is not reported in the current records. This peer review report states that the claimant underwent a left lower ganglion excision of September 6, 2007 and left wrist first extensor compartment release along with superficial radial nerve neuroma neuritis excision and implantation nerve and the muscle February 22, 2008. The rationale for the denial was stated as the clinician has not offered any electrodiagnostic testing to support the diagnosis of carpal tunnel syndrome. The physical examination findings are not supportive of carpal tunnel syndrome. The physician faxed the reviewer a copy of the new nerve studies. The recent nerve studies, performed on October 27, 2008, reportedly showed only early mild median nerve entrapment affecting the sensory component only.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

As noted above, the patient reportedly has early mild median nerve entrapment affecting the sensory component only. Given this information, she falls into the category of mild/moderate carpal tunnel syndrome. Findings upon physical examination include both a positive compression test and Tinel's sign. Thus, the patient meets the criterion in the ODG for physical examination findings in the category of mild/moderate carpal tunnel syndrome. In reviewing the medical records, and based on the fact that the patient has undergone previous surgical intervention, the patient has undergone an adequate trial of conservative management, satisfying the ODG criteria. However, two of the following symptoms are required to proceed with carpal tunnel release in the presence of mild/moderate carpal tunnel syndrome: Abnormal Katz hand diagram scores; nocturnal symptoms; and flick sign (shaking hand). The records fail to document that the patient has these symptoms. Based on this information, the patient does not meet the criteria specified by the ODG for proceeding with carpal tunnel release in the case of mild/moderate carpal tunnel syndrome. Therefore, my recommendation is to uphold the previous determination to non-certify the request for left wrist endoscopic CTR.

The IRO's decision is consistent with the following guidelines:

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL

____ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)

____ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

Official Disability Guidelines (2008)/Carpal Tunnel Chapter:

Carpal tunnel release surgery (CTR):

Recommended after an accurate diagnosis of moderate or severe CTS. Surgery is not generally initially indicated for mild CTS, unless symptoms persist after conservative treatment. See Severity definitions. Carpal tunnel release is well supported, both open and endoscopic (with proper surgeon training), assuming the diagnosis of CTS is correct. (Unfortunately, many CTR surgeries are performed on patients without a correct diagnosis of CTS, and these surgeries do not have successful outcomes.) Outcomes in workers' comp cases may not be as good as outcomes overall, but studies still support the benefits from surgery. Carpal tunnel syndrome may be treated initially with education, activity modification, medications and night splints before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits), but outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases. Nevertheless, surgery should not be performed until the diagnosis of CTS is made by history, physical examination and possible electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis, however the benefit from these injections although good is short-lived. Surgical decompression of the median nerve usually has a high rate of long-term success in relieving symptoms, with many studies showing success in over 90% of patients where the diagnosis of CTS has been confirmed by electrodiagnostic testing. (Patients with the mildest symptoms display the poorest post-surgery results, but in patients with moderate or severe CTS, the outcomes from surgery are better than splinting.) Carpal tunnel syndrome should be confirmed by positive findings on clinical examination and may be supported by nerve conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. Positive EDS in asymptomatic individuals is not CTS. Any contributions to symptoms by cervical radiculopathy (double crush syndrome) will not be relieved by the surgery. (Various references listed under "Surgical Considerations") (Chung, 1998) (Verdugo, 2002) (Shin, 2000) (AHRQ, 2003) (Lyll, 2002) (Gerritsen-JAMA, 2002) (Verdugo-Cochrane, 2003) (Hui, 2004) (Hui, 2005) (Bilic, 2006) (Atroshi, 2006) (Ucan, 2006) Being depressed and a workers' compensation claimant predicts being out of work after carpal tunnel release surgery. This highlights the importance of psychosocial management of musculoskeletal disorders. (Amick, 2004) (Karjalainen-Cochrane, 2002) (Crossman, 2001) (Denniston, 2001) (Feuerstein, 1999) Older age should not be a contraindication to CTR. (Weber, 2005) (Hobby2, 2005) In a sample of patients aged 70 years and older, patient satisfaction was 93 percent after surgical treatment versus 54 percent after nonsurgical treatment. (Ettema, 2006) Mini palm technique may be as good or better than endoscopic or open release. (Melhorn, 1994) (Cellocco, 2005) Steroid injections and wrist splinting may be effective for relief of CTS symptoms but the benefit decreases over time. Symptom duration of less than 3 months and absence of sensory impairment at presentation are predictive of an improved response to conservative treatment. Selected patients presenting with mild to moderate carpal tunnel syndrome (i.e., with no thenar wasting or obvious underlying cause) may receive either a steroid injection or wear a wrist night splint for 3 weeks. This will allow identification of the patients who respond well to conservative therapy and do not need surgery. (Graham, 2004) (Ly-Pen, 2005) See Injections. W hile diabetes is a risk factor for CTS, patients with diabetes have the same probability of positive surgical outcome as patients with idiopathic CTS. (Mondelli, 2004) Statistical evaluation identified five factors which were important in predicting lack of response to conservative treatment versus surgery: (1) age over 50 years; (2) duration over ten months; (3) constant paresthesia; (4) stenosing flexor tenosynovitis; & (5) a Phalen's test positive in less than 30 seconds. When none of these factors was present, 66% of patients were improved by medical therapy, 40% were improved with one factor, 17% were improved with two factors, and 7% were improved with three factors, and no patient with four or five factors present was cured by medical management. (Kaplan, 1990) Operative treatment was undertaken for 31% of new presentations of carpal tunnel syndrome in 2000. (Latinovic, 2006) In the treatment of carpal tunnel syndrome, decompression surgery produces a better long-term outcome than local corticosteroid injections, according to data presented at the American College of Rheumatology meeting. At 1 year, the results showed that local corticosteroid injection was as effective as decompression surgery; however, at 7 years, the estimated accumulated incidence of therapeutic failure in the corticosteroid group was 41.8% compared with 11.6% in the surgery group, because the effects of corticosteroid injections fade with time. (Ly-Pen, 2007)

ODG Indications for Surgery -- Carpal Tunnel Release:

I. Severe CTS, requiring ALL of the following:

A. Symptoms/findings of severe CTS, requiring ALL of the following:

1. Muscle atrophy, severe weakness of thenar muscles
2. 2-point discrimination test > 6 mm

B. Positive electrodiagnostic testing

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II. Mild/moderate CTS, requiring ALL of the following:

A. Symptoms (pain/numbness/paresthesia/impaired dexterity), requiring TWO of the following:

1. Abnormal Katz hand diagram scores
2. Nocturnal symptoms
3. Flick sign (shaking hand)

B. Findings by physical exam, requiring TWO of the following:

1. Compression test
2. Semmes-Weinstein monofilament test
3. Phalen sign
4. Tinel's sign
5. Decreased 2-point discrimination
6. Mild thenar weakness (thumb abduction)

C. Comorbidities: no current pregnancy

D. Initial conservative treatment, requiring THREE of the following:

1. Activity modification \geq 1 month
2. Night wrist splint \geq 1 month
3. Nonprescription analgesia (i.e., acetaminophen)
4. Home exercise training (provided by physician, healthcare provider or therapist)
5. Successful initial outcome from corticosteroid injection trial (optional)

E. Positive electrodiagnostic testing [note that successful outcomes from injection trial or conservative treatment may affect test results] (Hagebeuk, 2004)