

# P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA  
90211

Ph: (323)556-0555 Fx: (323)556-  
0556

## Notice of Independent Review Decision

MEDICAL RECORD REVIEW: 05/05/08

**DATE OF**

**REVIEW: 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 Orthopedic Surgeon, 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**

Right carpal tunnel release

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: Upheld (Agree)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records and prior reviews submitted for my review, the patient is an employee who sustained an industrial injury to the bilateral upper extremities associated existing disease versus cumulative trauma.

On April 27, 2006 the patient presented for evaluation and treatment to a medical provider. In-house electrodiagnostic studies showed bilateral, right greater than left, CTS and positive Tinel's bilaterally.

An orthopedic consultation was provided on May 11, 2006 per referral of the primary provider and conclusions noted carpal tunnel syndrome (CTS) and flexor tenosynovitis bilaterally. Recommendation was for a surgical intervention. On May 18, 2006, surgical intervention of left wrist flexor tenosynovectomies and trigger thumb release was provided. In a follow-up visit on June 8, 2006 the patient requested surgical intervention for the right wrist.

A Peer Review was requested and provided on July 7, 2006. Per the reviewer, the EMG-NCV studies were invalid as they did not comply with established standards for the validity of such diagnostics. The conditions listed by the surgeon naturally flow from the natural and progressive course of a pre-existing disease of life - degenerative joint disease. In addition, the patient is obese and there is no documentation that the patient sustained any identifiable injury mechanism at work. As well, the medical records failed to document and abnormal objective findings on physical examination, or a detailed description of the pattern and character

of the complaints that would be compatible with CTS. Per references, obesity and smoking are risk factors for CTS and neurological disorders.

On August 23, 2006, the patient initiated physical therapy for bilateral CTS and subsequently was provided approximately 12 visits.

The patient relocated and initiated treatment with a chiropractor on November 10, 2006. A diagnosis of bilateral CTS was provided and 12 sessions of treatment were requested. At follow-up visits in November of 2006 and on January 23, 2007 it was noted that the patient is waiting for authorization for physical therapy right carpal tunnel release. The patient requested leave of absence from her employment beginning February 20, 2007 anticipating a surgical intervention.

Request for physical therapy services, 8 - 12 visits, was not certified in review on February 22, 2007 with rationale that the medical necessity was not established. There was no history of surgery under the work injury claim and inadequate evidence to support additional evaluation. The request was also denied on appeal on March 13, 2007 with rationale that, per the provider, the request originated from the patient's prior treating provider and they were just continuing the recommended treatment. The patient was many months out from her May 2006 surgery and should have undergone an adequate course of rehabilitative therapy by that time.

On March 6, 2007 the provider wrote that he had been trying to get authorization for physical therapy for the patient's LEFT hand with goal of getting the left hand strong enough before the right hand surgery is performed.

A letter from the carrier of April 12, 2007 indicates that the mechanism of injury was lifting a 10 pound box of pillows and that perhaps both wrists should be accepted as industrial.

On April 19, 2007 the request for physical therapy went to IRO. The patient was post-op left carpal tunnel release (CTR). It was noted that a prior evaluator indicated right greater than left bilateral CTS but his symptom description stated left greater than right arm pain and tingling. Yet the evaluator's notes incorrectly stated the nerve studies showed left worse than right findings. Per peer review opinions, the nerve studies were invalid. The provider requested 12 post-op left wrist PT visits and right wrist PT on July 20, 2006. The patient has already had post-op PT in Texas. There was no evidence of any objective functional improvements from either the surgery or the therapy provided. The denial for appeal of post-op therapy was upheld.

Designated Doctor services were provided in July of 2007. The patient smokes cigarettes and is described as 5' 4" in height and 191 pounds. Left Phalen's was positive; Tinel was negative. Right wrist Phalen's and Tinel's were negative. The patient can return to light duty. MMI is anticipated in 2 months. The patient is looking for a Texas provider.

In October of 2007, the patient initiated treatment with a new medical provider. At initial exam of October 22, 2007 it was noted that the patient has numbness over the 4th and 5th fingers which are not normally supplied by the median nerve. She may have some kind of tardy ulnar palsy. She has a right CTS and a possible right ulnar neuropathy. X-rays of her wrist reveal a few little cysts in the distal radius but the boney architecture appeared to be satisfactory. We will send her for a neurological consultation.

A neurologic evaluation report was submitted on March 27, 2008. Nerve conduction studies were performed and show normal bilateral median motor distal latencies, conduction velocities and amplitudes. The patient has MILD right CTS and bilateral mild asymptomatic ulnar nerve slowing over the elbows. There is some left shoulder impingement. A right CTR might be considered.

The patient was seen by her primary provider in follow-up on March 31, 2008. He requested right carpal tunnel release to be performed on April 9, 2008.

Request for right carpal tunnel release was denied in review on April 4, 2008 with rationale that per recent EMG/NCV the patient has mild right CTS and continues to complain of CTS even though she is not working. The medical necessity was not established.

Request for reconsideration for right carpal tunnel release was denied on April 15, 2008 with rationale that the medical necessity was not substantiated as, per the clinical evidence reviewed, there was no mechanism to support surgical release for nature and extent of work incident.

On April 24, 2008 request was made for an IRO.

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

The medical records document normal nerve conduction studies in a patient symptomatic for right carpal tunnel syndrome. The medical records fail to document any objective functional improvements following a left CTR from either therapy, rest or medications. The patient is overweight and has some right ulnar nerve abnormalities per nerve studies. Plain films are unremarkable. The Designated Doctor documented negative right Phalen's and Tinel's signs. The patient also has non-industrial conditions of high blood pressure, cardiovascular dysfunction and left shoulder impingement. The medical records fail to document the patient's self-management program or weight loss attempt to reduce compression in the wrists. A left CTR has not resulted in any change in the patient's symptoms or overall condition. It can not be anticipated that a right surgical intervention would have a better result than the left intervention. The medical records fail to substantiate the medical necessity for a right carpal tunnel release. And finally, OGD states that surgery is not generally indicated for mild carpal tunnel syndrome. Therefore,

my determination is to agree with the previous non-certification of the request for right carpal tunnel release.

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

The Official Disability Guidelines -Carpal Tunnel release - 4-07-08

Recommended after an accurate diagnosis of moderate or severe CTS. Surgery is not generally indicated for mild CTS. 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 still support surgery. Carpal tunnel syndrome may be treated initially with a splint and medications 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 must be proved 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, however. (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 have a long-term effect in only some patients. Symptom duration of less than 3 months and absence of sensory impairment at presentation are predictive of a lasting response to conservative treatment. Selected patients (i.e., with no thenar wasting or obvious underlying cause) presenting with mild to moderate carpal tunnel syndrome may receive either a single steroid injection or wear a wrist 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. While 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 paraesthesiae, (4) stenosing flexor tenosynovitis, and (5) a Phalen's test positive in less than 30 seconds. When none of these factors was present, 66% of patients were cured by medical therapy, 40% of patients with one factor, 17% with two factors, and 7% 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

--- OR ---

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 THREE of the following:
  1. Durkan's 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 FOUR of the following:

1. Activity modification  $\geq$  1 month
2. Wrist splint  $\geq$  1 month
3. Nonprescription analgesia (i.e., acetaminophen)
4. Physical therapy referral for home exercise training
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)

Recommended after an accurate diagnosis of moderate or severe CTS. Surgery is not generally indicated for mild CTS. 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 still support surgery. Carpal tunnel syndrome may be treated initially with a splint and medications 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 must be proved by positive findings on clinical examination and may be supported by nerve conduction tests before surgery is undertaken. 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