

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 2, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left wrist neuroplasty, decompression median nerve, carpal tunnel

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

M.D. Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letter, Dr. 03/18/08

Adverse Determination Letter, Dr. 04/10/08

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Carpal Tunnel Syndrome: CTR

Office note of Dr., EMG/NCS report 12/12/06

MRI right wrist 03/28/07

MRI left wrist 03/28/07

Office note Dr. 04/17/07, 05/15/07, 10/02/07, 10/30/07, 11/27/07, 02/19/08, 03/18/08, 04/22/08

Dr. evaluation 12/20/07

Surgical request 04/03/08

Health insurance claim forms

Physical therapy records May 2007

PATIENT CLINICAL HISTORY [SUMMARY]:

A xx year old right hand dominant who had the onset of bilateral hand numbness and low back pain on xx/xx/xx. An EMG/NCS on 12/12/06 demonstrated findings consistent with bilateral carpal tunnel syndrome. There was no evidence of median nerve axonal loss and no clear evidence of radiculopathy.

MRI studies of both wrists were done on 03/28/07.

The left wrist MRI showed evidence of bony contusion with suggestion of hairline fracture involving the scaphoid bone, suggestion of a bony contusion in the lunate bone with fluid noted along the proximal and middle rows of carpal bones, strain on the radial collateral ligament with tendinosis involving the APL tendon and strain on the TFC was noted. A partial tear could not be completely excluded. Fluid was noted along the ulnar styloid process.

Notes from Dr. beginning 04/17/07 indicated diagnoses of bilateral carpal tunnel syndrome. The claimant was treated with wrist bracing and physical therapy. The notes of 05/15/07 documented bilateral wrist pain, weakness, popping and paresthesias. The same symptoms were recorded at the October visits. Mild bilateral thenar atrophy with positive Tinel and positive Phalen were documented. Carpal tunnel surgery was planned but apparently denied by the insurance carrier. Dr. indicated in a report dated 11/27/07 that the claimant had tried night splinting on a regular basis for 6 months. He had a positive Tinel and Phalen on exam and was showing some early thenar atrophy bilaterally.

On 12/20/07 Dr. performed an impairment rating and MMI evaluation. He noted that the claimant had been seen originally on 07/31/07 at which time he recommended surgical treatment for carpal tunnel syndrome. At the exam of 12/20/07 the claimant complained of pain of the hands and elbows bilaterally, severe with repetitive movements, squatting and bending his arms. He had numbness of the hands and weakness of the hands, forearms and shoulders. Medications included hydrocodone and a muscle relaxant. On exam the claimant was 5'7" and 280 pounds. There was no intrinsic, hypothenar or thenar atrophy noted. The claimant had tenderness of the elbows bilaterally, tenderness with crepitus of the wrists bilaterally and tenderness with crepitus of the hands bilaterally. Wrist range of motion was within normal limits. Muscle strength was normal. Reflexes were 2 plus. Phalen testing was positive bilaterally at 30 seconds, Tinel's was positive at the median nerve bilaterally. Two point discrimination was 6 mm in all fingers and thumb. Grip on the right was 75/70/60 and left 90/100/100. The diagnosis was bilateral carpal tunnel syndrome. Dr. indicated that the diagnosis was unequivocal based on history, exam and electrodiagnostic studies and felt the claimant needed surgery.

On 2/19/08 Dr. again requested carpal tunnel release. A peer review dated 03/18/08 by Dr. denied the surgical request. He made reference in his rationale to a carrier selected RME exam conducted 2/6/08 by Dr. who found no clinical evidence of carpal tunnel syndrome. Per Dr. exam the Tinel and Phalen's were negative. Dr. reported viewing a surveillance video of the claimant that showed him aggressively and freely using both hands and wrists in washing and drying automobiles. He was also observed driving over 90 mph. A second peer review on 04/10/08 upheld the denial of surgery.

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

In light of the conflicting medical findings, that being Dr. review showing no physical findings and those of Dr. who noted a positive Tinel's and Phalen's, I cannot approve the surgery with the inconsistencies noted. There is inconsistent, inconclusive medical documentation. The patient's subjective complaints appear to be somewhat excessive. In light of the conflicting medical information, I cannot approve the medical procedure as indicated at this time.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Carpal Tunnel Syndrome: CTR

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

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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 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](#))

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)