

MRI

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Notice of Independent Review Decision

DATE OF REVIEW: 4/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of outpatient right carpal tunnel release.

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

The reviewer is a Medical Doctor who is board certified in Orthopedics. The reviewer has been practicing for greater than 15 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of outpatient right carpal tunnel release.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The 2-17-10 dated AP letter was reviewed. Reference was made to a 12-17-09 dated +carpal tunnel syndrome electrodiagnostic. Pain, numbness, parasthesia, nocturnal symptoms along with + Tinel and muscle atrophy were noted, as was a failure of non-operative treatment. The 3-3-10 dated AP note documented poor two-point discrimination and that the claimant has had multiple + electrodiagnostics for Carpal tunnel syndrome, along with having done well post a left carpal tunnel release. Records from a Dr. were also reviewed, agreeing with the diagnosis and indication for surgery. Prior AP records were reviewed.

The 12-17-09 dated electrodiagnostic revealed "moderate" carpal tunnel syndrome." The 12-17-08 dated court order documenting the compensable repetitive motion disorder was noted.

The 2-16-10 and 2-26-10 dated denial letters were reviewed, with rationale for the denial having been noted. Rationale included the lack of a + result on the left wrist, the illegibility of notes and the multiplicity of symptoms and exam findings at other sites.

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

The AP has now evidenced all of the criteria for the diagnosis and treatment of right carpal tunnel syndrome. The claimant has at least two documented subjective findings (Nocturnal symptoms, numbness) and two objective findings (decreased 2-point discrimination, +Tinel and muscle atrophy) along with corroborating + electrodiagnostics for "moderate" carpal tunnel syndrome. The failure of multiple forms of non-operative treatments have been well documented. The existence of multiple other extremity symptomatic areas is irrelevant to the right-sided and accurate wrist diagnosis of carpal tunnel syndrome that has satisfied the applicable guidelines for surgery. The claimant has done reasonably well on the left side also. Therefore, the requested services is medically necessary.

Reference: ODG Guidelines regarding mild to moderate carpal tunnel syndrome

ODG Indications for Surgery™ -- Carpal Tunnel Release:

Not severe 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).
- See Injections. [Initial relief of symptoms can assist in confirmation of diagnosis and can be a good indicator for success of surgery if electrodiagnostic testing is not readily available.]
- E. Positive electrodiagnostic testing [note that successful outcomes from injection trial or conservative treatment may affect test results]

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 KNOWLEDGBASE
- 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)