



Notice of Independent Review Decision

DATE OF REVIEW: 07/05/11, AMENDED 07/14/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right Brown Carpal Tunnel Release
Right Pronator Release

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Hand Surgery

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Right Brown Carpal Tunnel Release – OVERTURNED

Right Pronator Release – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Electromyography/Nerve Conduction Study, M.D., 01/07/11
- Progress Note, D.O., 02/01/11, 03/29/11, 05/10/11, 06/07/11
- Nerve Conduction Study, M.D., 03/29/11
- Denial Letter, 04/19/11, 05/25/11
- Letter of Medical Necessity, Dr. 05/11/11
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a female who has complaints of bilateral hand and wrist pain with numbness and tingling, which include the thumb, index and long fingers. She also has complaints of severe pain in both forearms. She states these pain symptoms affect her sleep and have increased clumsiness. She has a history of cervical decompression and fusion. Electrodiagnostic studies performed in January of 2011 showed severe carpal tunnel syndrome on the right. There was no evidence of carpal tunnel syndrome on the left, no evidence of ulnar neuropathy or polyneuropathy in the upper extremities, and no evidence of active cervical radiculopathy. Second electrodiagnostic studies performed in March of 2011 showed severe right carpal tunnel entrapment in both motor and sensory involvement and right pronator teres entrapment of the medial nerve proximal forearm. Physical examination has revealed a positive Tinel's Sign at bilateral wrist and a positive Phalen's Test. A carpal tunnel release and pronator release of the right was recommended.

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

In my opinion, this patient has met the burden of proof for a right carpal tunnel release. An endoscopic carpal tunnel release remains a very viable and reasonable method of releasing the carpal tunnel. There have been some studies of a slightly increased risk of re-operation as stated in one of the previous denials of the surgery. However, there are certainly advantages that many feel outweigh the slight increased risk of re-operation. There is also still continued debate as to how real this increased risk of re-operation is. The endoscopic carpal tunnel release remains a viable and popular form of release of the carpal tunnel. By review, this patient does medically qualify for carpal tunnel release based on the severity of her right carpal tunnel syndrome, as revealed by physical examination and nerve conduction/EMG studies. By review, she appears to have failed bracing and other forms of conservative management including medications. Thus, I believe that the right endoscopic carpal tunnel release is indeed medically warranted for this patient's severe right carpal tunnel syndrome.

However, I do not believe that the right pronator release is warranted. I do not believe that this patient meets the criteria, nor has the burden of proof for approving the diagnosis of pronator syndrome been met. Pronator syndrome, in my opinion, is an often over-diagnosed problem. I can honestly say in my eight years of practicing hand surgery exclusively, I have released two pronators. In addition, there has been no documentation of any positivity in the examination for pronator syndrome other than forearm pain. I think the diagnosis of pronator syndrome by EMG would be very difficult to ascertain, and oftentimes misleading with many false negative and false positives. In addition to this, I feel that an endoscopic release of the pronator is foolhardy and, in my opinion, is certainly not a procedure that has been accepted and frequently used. There have been no studies, to my knowledge, of an endoscopic pronator release that has been confirmed as a safe procedure. I do not believe the burden of proof for pronator syndrome has been met in this claimant and thus, I do not believe that the right pronator release would be medically reasonable and necessary.

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)**
- AMA GUIDES 5TH EDITION**