SENT VIA EMAIL OR FAX ON
May/25/2011

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
May/24/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right Carpal Tunnel Release

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Orthopedic Surgery

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

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
1. Utilization review determination 03/07/11 regarding non-certification of request for right carpal tunnel release
2. Utilization review determination 03/23/11 regarding non-certification appeal request right carpal tunnel release
3. Fax cover sheet, patient information sheet and surgery pre-cert form 03/01/11
4. Initial evaluation M.D. 11/16/10
5. Electrodiagnostic report 02/08/11
6. Initial evaluation and follow-up office visit notes M.D. 03/01/11-04/19/11
7. Fax cover sheet, patient information sheet and surgery pre-cert form second request / appeal
8. MRI right shoulder 04/12/11

PATIENT CLINICAL HISTORY SUMMARY
The injured employee is a male whose date of injury is xx/xx/xx. Records indicate he fell approximately 3 feet sustaining a closed right clavicle fracture, multiple right sided rib fractures and a closed right distal radius fracture. The patient was treated conservatively. Records indicate the injured employee complains of numbness and tingling since the date of injury without improvement. Electrodiagnostic testing performed on 02/08/11 revealed evidence of severe right carpal tunnel syndrome. Physical examination performed on 03/01/11 reported an obvious asymmetry to the shoulders with obvious decreased clavicular length on the right with prominence in mid portion of the clavicle. Right wrist examination noted some generalized fullness. There was minimal glossiness to the skin, but there was no tenderness to light touch. Range of motion of wrist was 45 extension, 40 flexion. There was

positive Tinel's over the median nerve of the right hand. There was brisk capillary refill on tips of all fingers, 2.83SW sensation. The patient lacks about 2-3 cm of tips of fingers into the palms with 80 degrees of MP flexion and 80 PIP. The patient was seen in follow-up on 03/29/11. Examination at that time reported positive Tinel's over the median nerve; positive Phalen's; positive reverse Phalen's; positive median nerve compression test. Office visit noted the injured employee continued with numbness and tingling in the right hand with decreased range of motion. Numbness and tingling is all the time, nonspecifically worse at night. The injured employee underwent subacromial injection to the right shoulder.

A request for right carpal tunnel release was reviewed on 03/07/11 and determined to be non-certified as medically necessary. Review noted that ODG guidelines required documentation of conservative treatment such as activity modification, night wrist splint, non-prescription analgesic, home exercise program and documentation of successful initial outcome from optional corticosteroid injection. It was noted in this case the injured employee had no specific conservative treatment modalities documented. It was further noted that electrodiagnostic testing report was not available for independent review. Finally, it was noted that on examination there was only reference made to positive Tinel's sign, with no specific motor or sensory deficit noted and no evidence of motor weakness.

A reconsideration / appeal request was reviewed on 03/23/11, and again right carpal tunnel release was non-certified as medically necessary. The reviewer noted the request was no supported by the submitted clinical information. Records indicate the injured employee has developed a traumatic carpal tunnel syndrome. EMG/NCV has identified severe compression of median nerve in carpal tunnel, but the injured employee has only been treated with sporadic physical therapy. There was no data indicating the injured employee had been treated with bracing, activity modification or intracarpal injections. In absence of documentation to establish failure of conservative treatment, the request could not be established as medically necessary.

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

The clinical data submitted for review does not establish medical necessity for right carpal tunnel release. The injured employee is noted to have sustained an injury secondary to fall on xx/xx/xx. The injured employee was noted to complain of numbness and tingling since the date of injury without improvement. Electrodiagnostic studies reported severe right carpal tunnel syndrome. Examination on 03/01/11 reported positive Tinel's over the median nerve, with subsequent examination on 03/29/11 noting positive Tinel's, positive Phalen's, positive reverse Phalen's and positive median nerve compression test. Per ODG guidelines, indications for surgery for severe carpal tunnel syndrome require all of the following: symptoms / findings of severe carpal tunnel syndrome requiring all of the following: muscle atrophy, severe weakness of thenar muscles; two point discrimination test greater than 6 mm; and positive electrodiagnostic testing. While the patient is noted to have positive electrodiagnostic findings, there is no evidence of thenar atrophy or weakness and no evidence of two point discrimination test greater than 6 mm. Accordingly, ODG requires evidence of conservative treatment prior to surgical intervention for not severe carpal tunnel syndrome. There is no documentation provided demonstrating the injured employee has had any conservative treatment such as activity modification, night wrist splinting, anti-inflammatory medications, physical therapy / home exercise program, or corticosteroid injection. As such, the proposed right carpal tunnel release is not indicated as medically necessary at this time.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES