

INDEPENDENT REVIEWERS OF TEXAS, INC.

4100 West El Dorado Pkwy · Suite 100 – 373 · McKinney, Texas 75070

Office 469-218-1010 · Toll Free 1-877-861-1442 · Fax 469-218-

1030 e-mail: independentreviewers@hotmail.com

Notice of Independent Review Decision

DATE OF REVIEW: 05/03/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Requested: appeal of left brown endoscopic carpal tunnel release with pronator scope, decompression fasciotomy (64718, 26989, 25020)

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

Texas Board Certified Orthopedic Surgeon
Texas Board Certified Orthopedic Sports Medicine

REVIEW OUTCOME

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

Denial Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY
(SUMMARY):

The employee is a female with a history of carpal tunnel syndrome.

An MRI of the left wrist performed 03/19/10 demonstrated movement artifacts in some of the sequences. There were mild changes of osteoarthritis in the radiocarpal, intercarpal, and carpometacarpal joints. There was minimal synovial effusion in the intercarpal joints. There was mild subcutaneous edema around the wrist joint.

Electrodiagnostic studies performed 04/09/10 revealed mild left median neuropathy at the wrist. There was no electrodiagnostic evidence of left ulnar neuropathy at the wrist or elbow. There was no evidence of cervical radiculopathy.

The employee underwent left carpal tunnel release and left median nerve decompression on 05/25/10.

The employee saw Dr. on 07/01/10. The employee complained of left wrist pain rating of 8 out of 10. Physical examination revealed mild erythema in the

incisional area. There was a protruding stitch at the bottom of the incision. There was mild tenderness to palpation at the peri-incisional area. The employee was recommended for physical therapy.

The employee saw Dr. on 08/02/10 with complaints of recurring pain in the palm and wrist. The employee also reported weakness of the hand. Physical examination revealed tenderness to palpation at the hypothenar and thenar area. The employee was able to perform thumb opposition without difficulty except with the opposition of the thumb with the small finger. Grip strength was 4/5. There was mild edema noted. Tinel's was mildly positive at the left wrist. The employee was recommended for electrodiagnostic studies.

The employee was seen for Designated Doctor Evaluation on 10/14/10. The employee complained of left wrist pain rating of 6 out of 10. Physical examination revealed a well-healed non-tender scar of the left wrist. There was no hypothenar atrophy. The overlying skin shows no discoloration, ecchymosis, redness, warmth, or other lesions. There was no effusion or swelling noted. Range of motion was full. There was good grip and pinch formation. Sensation was intact. Radiographs of the left wrist demonstrated no evidence of fracture or dislocation. Radiographs of the left hand demonstrated no evidence of fracture or dislocation. Ultrasound of the left wrist and left hand was unremarkable. The employee was assessed with left wrist carpal tunnel syndrome status post left carpal tunnel release and left median nerve decompression. The employee was placed at MMI and assigned a 6% whole person impairment.

A Functional Capacity Evaluation (FCE) was performed on 10/14/10. The employee's occupation as a required a sedentary physical demand level. The note stated the employee met her reported lifting requirements. Electrodiagnostic studies performed 10/28/10 revealed evidence suggestive of a mild left sensory, demyelinating medianmononeuropathy at the wrist without denervation. There was no electrodiagnostic evidence of any other focal nerve entrapment, brachial plexopathy, or cervical radiculopathy in the left upper limb.

The employee saw Dr. on 12/15/10 with continued pain complaints. The employee reported loss of strength and dropping objects. Current medications included Lyrica, Lortab, Daypro, and Medrol Dosepak. Physical examination revealed positive Phalen's. There was thenar atrophy noted. There was decreased ability to oppose the thumb. There was forearm tenderness in zones V and VI. There was thenar tenderness to palpation. The employee was given a steroid injection to the left wrist.

The employee saw Dr. on 01/19/11. The employee reported no improvement with the steroid injection. Physical examination was unchanged. The employee was given a second steroid injection to the left wrist.

The employee saw Dr. on 01/31/11 with complaints of left hand pain. The employee reported no change in symptoms from the prior steroid injections. The employee reported hand weakness. Physical examination revealed positive Tinel's of the wrist. There was thenar atrophy noted. There was decreased ability to oppose the thumbs. There was positive forearm tenderness in zones V and VI. There was thenar tenderness to palpation. There was abnormal sensation in the ulnar aspect. The employee was assessed with carpal tunnel syndrome and median nerve entrapment. The employee was recommended for endoscopic carpal tunnel release.

The employee was seen for Designated Doctor Evaluation on 02/15/11. The employee

complained of pain at the left wrist with radiation to the left thumb rating of 7 out of 10. Physical examination revealed no gross significant abnormality of cranial nerves II to XII. Deep tendon reflexes were decreased at the left biceps, bilateral brachioradialis, bilateral triceps, bilateral patella, and bilateral Achilles. There were complaints of hypoesthesia throughout the left upper extremity dermatomes. There was mild muscle spasm of the upper trapezius and rhomboid muscles bilaterally. Cervical range of motion was restricted bilaterally. Maximum cervical compression test showed focal neck pain without radiation. There was mild vascular occlusion of the left ulnar artery on Allen's test. There was no sign of thenar or hyperthenar eminence atrophy. There was slight tenderness to palpation of the left thenar eminence. There was slight tenderness to palpation of the carpal bones. Range of motion of the right wrist was restricted due to pain. Phalen's was positive to the thumb and third digits. Tinel's was positive at the left carpal tunnel. There are complaints of pain in the left thumb with Finkelstein's test. The employee was assessed with left wrist carpal tunnel syndrome. The employee was not placed at MMI at that time.

The request for appeal of left brown endoscopic carpal tunnel release with pronator scope, decompression fasciotomy was denied by utilization review on 02/15/11. The employee's surgery was less than one year ago and electrodiagnostic studies only showed mild carpal tunnel syndrome. Postoperative course for the prior carpal tunnel release was not discussed. The employee's last surgery did not produce lasting benefit, and it was unclear how providing the same treatment was expected to result in a different or better outcome.

The request for appeal of left brown endoscopic carpal tunnel release with pronator scope, decompression fasciotomy was denied by utilization review on 03/04/11. The employee had positive Tinel's and Phalen's with thenar atrophy and abnormal two point sensation. No repeat studies had been obtained.

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

The requested appeal of left brown endoscopic carpal tunnel release with pronator scope, decompression fasciotomy is recommended as medically necessary. The employee's physical examination is consistent with left carpal tunnel syndrome. There is no indication from the clinical notes that the employee had any significant improvement with the last surgical procedure completed. The clinical documentation does demonstrate persistence of symptoms despite postoperative treatment. The employee also has positive electrodiagnostic findings. As such, medical necessity is established.

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

Official Disability Guidelines, Online Version, Carpal Tunnel Syndrome Chapter

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] (Hagebeuk, 2004)