

Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/23/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

left carpal tunnel release 64721

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

M.D., Board Certified General Surgery; Fellowship trained Orthopedic Hand and Upper Extremity 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 medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for left carpal tunnel release 64721 is not supported as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Notification of adverse determination 04/19/12
Notification of reconsideration determination 06/18/12
Patient visit charting notes 06/25/12
Reconsideration / preauthorization request 05/21/12
Office visit notes 07/21/11-04/09/12
X-rays bilateral wrists 02/27/12 and 07/21/11
EMG/NCV 06/02/11
Designated doctor's evaluation 10/26/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female whose date of injury is xx/xx/xx. After lifting a few 10 lb bags she reported feeling numbness and tingling in both hands and wrists. She was diagnosed with tenosynovitis of both wrists, and prescribed Medrol DosePak and Naprosyn. X-rays of right wrist on 07/21/11 showed soft tissue swelling but no significant osseous abnormality. Electrodiagnostic testing on 06/02/11 reported evidence of mild bilateral carpal tunnel syndrome right greater than left. The claimant was seen on 04/09/12 for follow-up of left carpal tunnel syndrome. She complained of left hand pain / numbness. Records indicate the claimant was scheduled for surgery but surgery was cancelled because symptoms went away. She states she has been wearing night splints which helped right hand / wrist but not helping the left. She is on Meloxicam without GI symptoms. EMG/NCV in 06/11 showed mild carpal tunnel syndrome right greater than left. The claimant denies radicular myelopathic symptoms. Injection of left carpal tunnel was performed in 02/12 and claimant states her symptoms have not improved at all. Physical examination of the left upper extremity reported distal radial ulnar joint is stable to ballottement grind test, snuff box tenderness, Watson's

shift test, Finkelstein's were negative. There was no tenderness at lunotriquetral or scapholunate ligaments. Tinel's and Phalen's were negative. There was no wasting/atrophy/weakness. Sensation was grossly intact. Fingers have full active and passive range of motion in all joints and no cross over or rotational deformity with fully intact flexor and extensor function throughout. There was no concern for neurovascular compromise or infection. There is no clinical evidence of weakness, atrophy, or wasting; sensory deficits; nor any signs of vascular embarrassment or on examination.

A request for left wrist carpal tunnel release was denied on 04/19/12 noting there was no documentation of at least 2 findings of physical examination (Durkan's compression test, Semmes-Weinstein-Monofilament Test, Phalen's sign, Tinel's sign, decreased two point discrimination, and / or mild thenar weakness (thumb abduction). A reconsideration request was denied on 06/18/12 noting the request was previously denied due to no documentation of at least two findings by physical examination, and there still is no clear documentation that address proposed surgery without specific evidence of carpal tunnel syndrome including positive provocative test. Also the documented analysis of recent electrodiagnostic studies of left upper extremity was not submitted for review with mild disease in previous study. There is no documentation provided with regard to failure to respond to conservative treatment.

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

The claimant reportedly was injured on xx/xx/xx due to repetitive lifting of 10-pound bags. She failed to improve with conservative treatment including splints, injection of the left carpal tunnel, anti-inflammatory medications, and activity modification. Electrodiagnostic testing reported evidence of mild bilateral carpal tunnel syndrome right greater than left. According to the records the claimant's right-sided symptoms resolved with conservative treatment, but she continues to remain symptomatic on the left side. While it is noted that the claimant has subjective complaints, examination revealed no evidence of nocturnal symptoms or flick sign. Also, there should be at least two findings by physical examination including compression test, Sid Weinstein monofilament test, Phalen's sign, Tinel's sign, decreased two-point discrimination, and/or mild thenar weakness (thumb abduction). There were no findings consistent with carpal tunnel syndrome reported on clinical examination. Therefore, the reviewer finds no medical necessity for left carpal tunnel release 64721 at this time.

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

- ACOEM-AMERICA 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)