



3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069
Ph 972-825-7231 Fax 972-274-9022

Notice of Independent Review Decision

DATE OF REVIEW: 7/6/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of Right Carpal Tunnel Release, Right Cubital Tunnel Re-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 Orthopedic 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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of Right Carpal Tunnel Release, Right Cubital Tunnel Re-Release.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

PATIENT CLINICAL HISTORY [SUMMARY]:

The Attending Physician records were reviewed. The is status post right carpal tunnel release in 11/11. This was after a x/xx dated unknown mechanism of injury. As of 5/9/12, there was persistent numbness and tingling in the right thumb, index, ring and small fingers. Exam findings include a positive wrist and elbow’s Tinel’s , weak intrinsics, and decreased sensation in the median and ulnar nerve distributions. Electrical studies (from 3/23/11) had revealed moderate carpal tunnel syndrome and right elbow neuropathy. The Attending Physician noted that the post-operative 2/14/12 dated MRI noted “flattening of the nerve.” Treatment has included splinting, therapy, restricted activities and medications as per the Attending Physician letter dated 6/5/12. Therapy records were also reviewed. The 2/14/12 dated denial letters denoted the lack of comprehensive conservative treatment and the lack of repeat corroborative electrical studies.

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

The patient has clinical and MRI findings of carpal tunnel syndrome. The subjective and

objective findings have not responded to non-operative treatment of splinting and medications and restricted activities over months. The surgical release of the carpal tunnel was noted, however, the MRI denotes nerve compression. This is a strong corroborative test rendering and additional electrical studies superfluous, especially when the subjective and objective exam findings are noted.

The clinical and electrical findings of cubital tunnel syndrome have also been established. They have persisted despite extensive non-operative treatments also. Applicable ODG criteria have been met and the requested procedures are medically necessary at this time.

Reference: ODG Carpal Tunnel Syndrome Chapter

ODG Indications for Surgery -- Carpal Tunnel Release:

I. Severe CTS, requiring ALL of the following:

A. Symptoms/findings of severe CTS, requiring ALL of the following:

1. Muscle atrophy, severe weakness of thenar muscles
2. 2-point discrimination test > 6 mm

B. Positive electrodiagnostic testing

--- OR ---

II. 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)

ODG Elbow Chapter

ODG Indications for Surgery -- Surgery for cubital tunnel syndrome: Initial conservative treatment, requiring ALL of the following:

- Exercise: Strengthening the elbow flexors/extensors isometrically and isotonicly within 0-45 degrees

- Activity modification: Recommend decreasing activities of repetition that may exacerbate the patient's symptoms. Protect the ulnar nerve from prolonged elbow flexion during sleep, and protect the nerve during the day by avoiding direct pressure or trauma.

- Medications: Nonsteroidal anti-inflammatory drugs (NSAIDs) in an attempt to decrease inflammation around the nerve.

- Pad/splint: Use an elbow pad and/or night splinting for a 3-month trial period. Consider daytime immobilization for 3 weeks if symptoms do not improve with splinting. If the symptoms do

improve, continue conservative treatment for at least 6 weeks beyond the resolution of symptoms to prevent recurrence

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)