

# **MATUTECH, INC.**

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Notice of Independent Review Decision

**DATE OF REVIEW: January 6, 2012**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Outpatient Release of right carpal tunnel to include CPT codes 64721, 29125

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

Board Certified Orthopaedic Surgeon

American Board of Orthopaedic Surgeons

Specializes in arthritis management for the elbow, wrist and fingers; arthroscopic wrist surgery, including endoscopic carpal tunnel release; treatment of fractures, dislocations and ligament injuries; diagnosis and treatment of congenital hand conditions

**REVIEW OUTCOME**

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG has been utilized for the denials.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained a work-related injury to her right upper extremity on xx/xx/xx. The patient was walking down a ramp when she slipped on loose sand and gravel. She fell to the right side and broke her fall with her right arm/hand. She used the same hand to lift herself up off the ground.

On xxxxxx, x-rays of the right wrist showed subtle lucency at the waist of navicular bone raising the possibility of nondisplaced fracture and mild soft tissue swelling dorsal to carpal bones. X-rays of the lumbosacral spine showed exaggerated lordosis with multilevel mild degenerative changes.

On xxxxxx, the patient was seen at for right wrist pain. The patient had been already seen in an emergency room (ER) where she was x-rayed and treated with ibuprofen and Flexeril. Examination revealed mild swelling and tenderness and painful range of motion (ROM) of the right upper extremity. The patient was diagnosed with fall from slipping, tripping or stumbling and joint pain. She was instructed to use an arm sling, to keep her arm elevated, use hand immobilizer, continue medications prescribed by the ER doctor, start Tylenol with codeine and use ice/heat therapy. In the following visit, a Colles' splint was applied instead of the wrist splint.

On May 26, 2011, M.D., a hand surgeon, evaluated the patient for right wrist pain and right elbow pain. Examination revealed tenderness at the dorsal and radial sides of the right wrist and tenderness at the dorsal and lateral epicondyle of the right elbow. X-rays of the right wrist showed nondisplaced middle 1/3<sup>rd</sup> scaphoid fracture while x-rays of the right elbow showed no fracture or dislocation. Dr. diagnosed contusion of the right elbow, closed fracture of the right navicular bone and right shoulder/arm sprain, prescribed Vicodin for pain and applied a short-arm fiberglass thumb spica cast. He opined that the wrist injury could be treated conservatively with six weeks of immobilization and then therapy could be considered. In the following visit, Dr. obtained x-rays of the right wrist which showed healed nondisplaced middle 1/3<sup>rd</sup> scaphoid fracture. He recommended continuing the previous medications and instructions.

On August 25, 2011, D.C., performed a maximum medical improvement/impairment rating (MMI/IR) evaluation and opined that the patient had reached MMI on August 19, 2011, with 9% whole person impairment (WPI) rating. Per DWC73, patient was allowed to return to work without restrictions.

On October 7, 2011, Dr. evaluated the patient and noted positive minimal right wrist stiffness, positive right wrist Tinel's and compressions tests and tenderness at the dorsal and radial sides of the right wrist and at the lateral epicondyle of the right elbow. He prescribed Mobic, applied a right elbow protector elastic orthosis and recommended an electromyography/nerve conduction (EMG/NCV) study.

On October 25, 2011, M.D., evaluated the patient for neck pain. On the previous day, the patient injured her neck and elbow when she slipped on water while sweeping under the tables. She presented with persistent pain in the neck that radiated to the right shoulder and upper extremity. There was also pain in the upper back with tightness of the neck essentially in the morning. There was some intermittent numbness and tingling sensation in the right upper extremity all the way down to the fingertips. She also presented with some weakness of the right arm because of the pain. She complained of intermittent pain in the right elbow and wrist. The pain was worsening with repetitive use of the right arm especially with lifting as well as overhead activities. Examination of the cervical spine revealed straightening of the normal lordosis. Active range of motion (AROM) of the neck was restricted with pain at the end of range. Axial compression of the head was productive of pain at the base of the neck but with negative Spurlings sign. Tenderness was noted over the cervical spinous processes, paracervical muscles and at the splenius capitis. There was tightness of the paracervical muscles and tenderness at the scapular area. ROM of the right shoulder was limited with pain at the end of range. The right acromioclavicular (AC) joint was tender. Dr. diagnosed cervical strain/sprain,

cervical disc disease, cervical radthy, myofascial pain syndrome, right wrist fracture and right elbow sprain/strain. He continued medications prescribed by Dr. and recommended an EMG/NCV study of the upper extremities to rule out radiculopathy, brachial plexopathy and focal mononeuropathy.

On October 28, 2011, M.D., a designated doctor, evaluated the patient to determine impairment rating (IR). He opined that according to the American Medical Association (AMA) Guidelines the patient would need an additional workup before the IR could be assigned. The reason was that the patient suffered an additional fall on October 24, 2011, with injury to her right upper extremity.

An electrodiagnostic study performed on November 15, 2011, by Dr. showed electrophysiologic findings of right C5 and C6 nerve root irritation and findings of early right sensory median neuropathy (carpal tunnel syndrome).

On November 30, 2011, Dr. reviewed the EMG findings and diagnosed right carpal tunnel syndrome (CTS). He opined that a release of the right carpal tunnel would be beneficial for the patient.

Per utilization review dated December 5, 2011, the request for carpal tunnel release (CTR) was denied with the following rationale *“(1) There was no documentation of splinting specifically for CTS. (2) There was no description of symptoms to support CTS, specifically no documentation of numbness in a median nerve distribution. (3) The records indicated that the patient had neck pain radiating into the right upper extremity with EMG evidence of C5 and C6 nerve root irritation. (4) Official Disability Guidelines (ODG) criteria were not met.”*

Per reconsideration review dated December 13, 2011, the appeal for right CTR was denied with the following rationale: *“22 pages +42 pages of records reviewed. On December 5, 2011, this same requested service was denied, and since that date there is no discernible documentation from the requestor which specifically and clearly addresses the rationale on which that previous denial was based. In the note of October 7, 2011, there was no discernible listing of a diagnosis of CTS. Report of the electrodiagnostic study on November 15, 2011, indicated that the temperature was 31.5 degree Celsius. However, this study did not fulfill the standards for validity for such studies as established by the American Association of Electrodiagnostic Medicine Guidelines which requires that the surface temperature of the tested extremity be validated to be at least 32 Celsius. She presented with neck pain that radiated to the right upper extremity with some numbness and tingling sensation. The provider listed the fourth diagnosis as carpal tunnel syndrome on the right. Notably absent was any documentation that a physical examination was performed. Since the study was not documented to fulfill the standards for validity, it was reasonable to conclude that no diagnosis of right carpal tunnel syndrome was validated to be present in this patient. In the DWC-69 of October 28, 2011, no diagnosis of right CTS was listed. In the undated Designated Doctor Report was the entry of abnormal sensation of the median nerve and ulnar nerves, but no details of the method of testing were documented. Any validated medical diagnosis should be based on correlation of three elements (prongs); [1] the detailed history and pattern of symptoms (complaints) from a patient; if a nerve is thought to be involved, then*

*the detailed description of the pattern of the symptoms must correlate with the involved nerve diagnosis. [2] The objective abnormal findings on a properly-performed and documented physical examination; in neurological conditions, Phalen's and Tinel's and Duran's maneuver's were not objective-graded weakness (Highest Scale), observed atrophy of specific muscles, and deformities secondary to neuropathy were objective. [3] Abnormal objective findings demonstrated on properly-performed diagnostics. Relating to electrodiagnostic studies, there must be documentation that the study was performed in compliance with the standards for validity as established by the American Association of Electrodiagnostic Medicine Guidelines (1993). In this case those criteria have not yet been fulfilled. Additionally, noted was the Official Disability Guidelines/Treatment in Workers' Compensation (evidence-based protocols) criteria."*

Per DWC73, patient was released to full duty without restrictions as of December 14, 2011, by Dr..

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

The medical necessity for release of the right carpal tunnel has not been established in this case. The claimant has complained of pain and numbness in a non-specific dermatomal pattern and there is no documentation of conservative care with splinting, home exercise program/therapy, and or of activity modification. The clinical information does not satisfy the Official Disability Guidelines for proceeding with right carpal tunnel release and the determination is upheld.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES