

SENT VIA EMAIL OR FAX ON
Jan/18/2012

Pure Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Jan/18/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Revision Left Carpal Tunnel Release Hypothenar Fat Pad Graft; Left Thumb Trigger Release

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Notification of determination 12/22/11
Utilization review appeal determination 01/06/12
Office visit notes M.D. 10/13/09-12/08/11
EMG/NCV 11/17/11
MRI left wrist 10/03/11
Preauthorization request 12/14/11
Preauthorization request 12/28/11

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate he slipped and fell off train car and fractured his left wrist and injured his left shoulder. The injured employee developed frozen left shoulder and had manipulation under anesthesia. He was noted to have external fixator in place on his left arm for while. The injured employee subsequently underwent left carpal tunnel release on 06/04/08. On 09/10/08 he underwent

left wrist arthroscopy with triangular fibrocartilage complex debridement. The claimant continued to complain of left trigger thumb, left wrist pain, and left hand weakness. MRI of left wrist performed 10/03/11 revealed obvious old fracture of distal radius and ulnar styloid. The normal dark structure of TFCC is not present and is likely chronically degenerated. Some degenerative change was noted developing in radial carpal joint itself. Frank leakage of contrast into soft tissues on lateral aspect of wrist joint imply capsular disruption which could be more acute injury. The increased scapholunate angle suggests dorsal intercalated segment instability. Electrodiagnostic testing performed on 11/17/11 revealed findings consistent of carpal tunnel syndrome with motor and sensory fibers affected in left wrist. No ulnar neuropathy was identified in left upper extremity. There was no left C5-T1 radiculopathy identified. No generalized peripheral neuropathy was identified. The injured employee was seen by Dr. on 12/08/11. It was noted the injured employee was last seen on 11/17/11 and given steroid injection in carpal tunnel region which had about less than 50% relief of symptoms lasting for about a day. Examination of left wrist reported no radial carpal effusion. Range of motion testing revealed extension 55 degrees and flexion 35 degrees. There was mild tenderness noted in triangular fibrocartilage complex fossa, without instability of DRUJ. There was good digital range of motion. No fasciculations were seen in left or right thenar or hyperthenar groups. Tinel's sign was negative. Direct median nerve compression test and Phalen's were negative. Tinel's sign was mildly positive over median nerve. Left thumb examination reported tender nodule over the A1 pulley region and loose with flexor excursion. The left thumb interphalangeal joint has no effusion and 0-60 degrees of flexion. The left thumb metacarpophalangeal joint is stable. The injured employee was recommended to undergo revision carpal tunnel release with hyperthenar fat pad grafting as well as trigger thumb release.

A preauthorization review was performed on 12/22/11 and determined request for revision left carpal tunnel release, hyperthenar fat pad graft and left thumb trigger release as not certified as medically necessary. It was noted medical records indicate the injured employee has been given carpal tunnel injection on left side and has been wearing a splint. He has electrodiagnostic evidence of left carpal tunnel syndrome with motor and sensory fibers affected. Guidelines indicate for carpal tunnel that is not severe there should be symptoms such as nocturnal symptoms, flick sign, and should be finding on physical examination such as compression test, Phalen's sign, Tinel's sign or decreased two point discrimination. There should also be evidence of mild thenar weakness. There should be conservative care in form of activity modification, wrist splints, prescription analgesia, home exercise program, or corticosteroid injection. Medical records indicate the injured employee has had corticosteroid injection without significant relief. He has been wearing splints. He has negative Phalen's sign. It is noted Tinel's sign is mildly positive over median nerve. Direct median nerve compression test was negative. The injured employee does not demonstrate significant finding on physical examination that correlate with current criteria of carpal tunnel release. As such, the request for carpal tunnel release is not considered medically necessary. There is no indication of thenar eminence or hyperthenar eminence atrophy. The case was discussed with. Clinical records indicate the injured worker has trigger finger on the left thumb, but medical records do not demonstrate any conservative care for this trigger finger prior to going to surgery as recommended by guidelines. As such request for left thumb trigger release is not considered medically necessary.

An appeal request for revision left carpal tunnel release hyperthenar fat pad graft and left thumb trigger release was reviewed on 01/06/12, and the request was determined as non-certified as medically necessary. The reviewer noted that guidelines would not support left thumb trigger finger release without lower levels of care having been exhausted including steroid injection into the thumb. Records do not reflect the injured worker has undergone steroid injection into the thumb. Guidelines would not support revision left carpal tunnel release without symptoms requiring two of the following abnormal cats hand diagrams course, nocturnal symptoms or flick sign. Claimant is not documented to have any of these symptoms. Physical examination documents only Tinel's as mildly positive over the median nerve. As such the request is non-certified.

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

The clinical data provided for review does not support a determination of medical necessity for left carpal tunnel release hyperthenar fat pad graft, and left thumb trigger release. Claimant is noted to have sustained injury secondary to fall on xx/xx/xx. He has a history of previous surgical intervention including manipulation under anesthesia of the left shoulder, left carpal tunnel release, and left wrist arthroscopy with TFCC debridement. The injured worker continued to complain of left trigger thumb, with left wrist pain and left hand weakness. Electrodiagnostic testing on 11/17/11 revealed left carpal tunnel syndrome with both motor and sensory fibers affected, with no ulnar neuropathy in the left upper extremity and no cervical radiculopathy identified. Most recent progress note dated 12/08/11 indicated that the injured worker experienced less than 50% relief of symptoms lasting for about a day with steroid injection in the carpal tunnel region. Left carpal tunnel exam reported Tinel's sign is negative; direct median nerve compression test and Phalen's test negative; Tinel's sign mildly positive over the median nerve. There was no evidence of active triggering of the left thumb, with tender nodule noted over the A1 pulley region that moves with flexor excursion. The injured worker has had splinting in addition to injection of the carpal tunnel region. However there is no indication of activity modification, home exercise and medications. Per Official Disability Guidelines, criteria for surgery for not severe carpal tunnel syndrome require all of the following; at least two of the following abnormal cats hand diagram scores, nocturnal symptoms, or flick sign; findings by physical examination requiring two of the following: compression test, Semmes Weinstein Monofilament test, Phalen's sign, Tinel's sign, decreased two point discrimination, mild thenar weakness; exclusion of comorbidities; initial conservative treatment requiring three of the following activity modification, night wrist splint, non-prescription analgesia, home exercise training and successful initial outcome from corticosteroid injection trial. Documentation presented does not demonstrate abnormal cats hand diagram scores, nocturnal symptoms, or flick sign. There is mildly positive Tinel's sign, but no indication of decreased two point discrimination, Phalen's sign or carpal compression test. As previously noted the initial conservative treatment does not meet criteria as specified in Official Disability Guidelines. As such medical necessity is not established for revision left carpal tunnel release hyperthenar fat pad graft.

Regarding left thumb trigger release, there is no documentation that a trial of corticosteroid injection for the trigger thumb has been attempted. According to Official Disability Guidelines one or two injections into or near the thickened area of the flexor tendon sheath of the affected finger are almost always sufficient to cure symptoms and restore function. When symptoms persist, trigger finger release may be appropriate. Noting the lack of documentation of trial of steroid injection to the left thumb, medical necessity is not established.

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

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

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES