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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 10/22/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an outpatient surgical procedure right carpal tunnel release to include CPT 64721.

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. The reviewer has been practicing for greater than 10 years.

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 an outpatient surgical procedure right carpal tunnel release to include CPT 64721.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Comp.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 9/27/12 denial letter with report, 9/14/12 denial letter with report, 6/6/12 to 8/30/12 orthopedic reports by, MD, 7/26/12 neurodiagnostic report, 6/19/12 right wrist MRI report, 5/14/12 right wrist radiographic report, 5/14/12 report by MD, 3/18/12 to 3/22/12 reports by MD, and handwritten and typed notes by, MD dated 3/5/12 and 3/6/12.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The reportedly tripped and fell onto her outstretched right upper extremity on XX/XX/XX. She was noted to have developed pain and numbness in the hand and a diagnosis of post-traumatic carpal tunnel syndrome. A review of the initial notes postdate of injury did not reflect such numbness or tingling. Symptoms of hand clumsiness and intermittent numbness, tingling and weakness have been documented in the AP records. "Nighttime symptoms" were documented on 8-31-12. Exam findings have included some tingling with carpal pressure without other carpal-tunnel associated findings, as of 8/31/12. There had previously been a positive Tinel sign and snuffbox region tenderness, the later gradually becoming more global in nature. The 6/19/12 dated MRI report suggested carpal tunnel syndrome. The 7-16-12 dated electrical study was unremarkable. There was a positive response to a cortisone injection. Treatment has also involved splinting and activity restriction. The provider has indicated that the patient falls within the category of electro-diagnostic negative carpal tunnel syndrome. Denial letters discussed the lack of objective and electrical findings evidencing a diagnosis of carpal tunnel syndrome.

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

The claimant's mechanism of injury supports the plausibility of trauma in the region of the carpal canal. The claimant has ongoing subjective numbness and tingling, weakness and hand clumsiness, along with nocturnal symptoms. The claimant has been noted to have a positive wrist compression test and has been noted at various points in time to have a positive Tinel. Although the electrical studies have been noted to be unremarkable, guidelines also indicate "successful outcomes from injection trial or conservative treatment may affect test results." The MRI findings corroborate the clinical findings and lack of response to non-operative treatment.

Therefore at this time the claimant has findings that have met the intent/guideline criteria in that reasonable non-operative treatment of activity modification, splinting and injection have not been able to resolve the condition. The findings support that the diagnosis is positive for carpal tunnel syndrome and the request is reasonable and medically necessary.

Reference: 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]

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)