

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/04/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

outpatient right carpal tunnel release

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

M.D., Board Certified 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds the proposed outpatient right carpal tunnel release is not indicated as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Notification of reconsideration determination 08/07/12
Notification of adverse determination 06/05/12
Referring doctor maximum medical improvement impairment rating 07/05/11 and follow-up 07/13/11
Progress note 06/25/12 and 05/25/12
Office notes 01/04/11-07/06/12
Electromyography and nerve conduction velocity study 01/21/11
Occupational therapy hand / upper extremity evaluation and progress notes 01/06/11-01/28/11
Occupational therapy initial evaluation, progress notes and reassessment 02/16/12-05/10/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female with a date of injury of xx/xx/xx. The mechanism of injury is described as repetitive type activity. She has bilateral hand and elbow pain. She has been treated conservatively with medications and physical therapy. Electrodiagnostic testing performed on 01/21/11 revealed some slight median neuropathy at wrist without ulnar neuropathy and no cervical radiculopathy. The claimant is status post left carpal tunnel release on 01/25/12. She reported that her left hand was doing better after surgery. Progress note dated 05/18/12 indicated the claimant states surgery definitely helped her left arm. She has less burning and pain. There was still some discomfort in forearm. The claimant is still having numbness and tingling to right hand. Examination of left hand demonstrated the claimant was moving fingers well. There is mild tenderness to forearm compartments. There is full range of motion of elbow with mild discomfort. Right hand demonstrates positive Phalen's sign. Right carpal tunnel release was recommended.

A request for outpatient right carpal tunnel release was non-certified by utilization review dated 06/05/12. It was noted that the claimant complained of numbness and tingling in right hand per medical report dated 05/18/12. Examination of the right hand reported positive Phalen's test. Electrodiagnostic studies on 01/21/11 showed only slight median neuropathy. Conservative treatment includes physical therapy to the left hand; however, there is no clear documentation of at least 2 symptoms including abnormal KATZ hand diagram, nocturnal symptoms, and / or flick sign (shaking hand).

In addition there was no documentation of at least 1 additional finding by physical examination to include Durkan's compression test, Semmes-Weinstein Monofilament test, Tinel's, decreased 2 point discrimination, and / or mild thenar weakness (thumb abduction). Furthermore, there was no clear documentation of at least 3 conservative treatment measures attempted for the right hand including activity modification greater than 1 month, wrist splinting greater than 1 month, non-prescription analgesia, and physical therapy referral for home exercise training and / or successful outcome from corticosteroid injection trial. The request was denied a second time on 08/07/12 noting the records did not provide documentation that addressed the issues raised on previous non-certification. The current objective findings still do not suggest the presence of carpal tunnel syndrome, and there was still no evidence of recent conservative treatment employed to the right wrist/hand such as physical therapy and/or a corticosteroid injection.

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

The claimant is noted to have sustained repetitive motion injury to her bilateral hand / wrist. Electrodiagnostic testing performed on 01/21/11 reported evidence of slight median neuropathy at the wrist. The claimant is status post left carpal tunnel release performed on 01/25/12 followed by postoperative physical therapy. In accordance with the ODG, there is no documentation the claimant has had an appropriate course of conservative treatment to her right wrist including any recent physical therapy / home exercise program, night splinting, anti-inflammatory medications, or corticosteroid injections. The only finding reported on physical examination for the right wrist is positive Phalen's. According to ODG guidelines there should be at least two of the following: abnormal KATZ scan diagram scores, nocturnal symptoms, flick sign. There also should be two of following findings by physical examination: compression test, Semmes-Weinstein Monofilament test, Phalen's sign, Tinel's sign, decreased two point discrimination, and mild thenar weakness. Noting the lack of appropriate findings required by ODG, and the lack of documentation regarding initial conservative treatment, the reviewer finds the proposed outpatient right carpal tunnel release is not indicated as medically necessary.

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)