

Medical Assessments, Inc.

4833 Thistledown Dr.
Fort Worth, TX 76137
P: 817-751-0545
F: 817-632-9684

Notice of Independent Review Decision

August 31, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Rt Wrist Neuroma Excision, RCT release 64721, 25295, 64774, 15002, 11400, 12041

RUSH:OP:Rt Keloid Excision & FCR Tenolysis w/Layered Closure

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

The Reviewer is Board Certified in the area of Plastic Surgery with a subspecialty of Surgery of the Hand and has over 13 years of experience.

REVIEW OUTCOME:

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

Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

March 28, 2012: Operative report

October 4, 2012: Evaluation

October 17, 2012: Evaluation

November 27, 2012: EMG/NCS of the Upper Extremities

December 4, 2012: Follow up Evaluation

January 9, 2013: Follow up Evaluation

February 26, 2013: Follow up Evaluation

May 24, 2013: Designated Doctor Evaluation

July 11, 2013: Evaluation

July 18, 2013: UR performed

07/30/ 2013: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was initially injured on xx/xx/xx. The current diagnoses are mononeuritis of the upper limb, keloid scar, forearm joint pain and joint ganglion. An appeal request was made for right keloid scar excision with multilayer closure, excision of cutaneous neuroma of the right wrist, carpal tunnel release and tenosynovectomy.

March 28, 2012: Operative Report, Postoperative Diagnosis: Posttraumatic volar radial ganglion status post wrist sprain. Operation Performed: Excision of volar radial ganglion, right wrist.

October 4, 2012: Evaluation. Plan: opined that he thought she basically had a neuroma with hypertrophic scar and that a brace irritates it. Although she had never had therapy, he recommended sending her to a hand surgeon subspecialist for consideration of a scar revision with exploration treatment of the neuroma if present.

October 17, 2012: Evaluation. Claimant presented with complaints of right hand dysesthesias. The claimant complained of pain in the right wrist. On physical exam the right hand and wrist reveals a healed, hypertrophic very sensitive scar over the volar radial aspect of the right wrist. No recurrent ganglion cyst is noted. There is a positive Tinel's test in the area of the scar. Sensation is diminished in the median nerve distribution with a positive Tinel's, Phalen's, and median nerve compression test. No atrophy is noted but there is weakness of the abductor pollicis brevis. Plan: Sent claimant for an EMG to evaluate. Gave topical nerve desensitization cream and Cica-care to help soften the scar.

November 27, 2012: EMG/NCS of the Upper Extremities. Electrodiagnostic Impression: 1. There is evidence of mild-moderate right median neuropathy at the wrist that affects both sensory and motor fibers, without definite conduction block or loss of sensory axons, but with APB active denervation on needle EMG. In this patient's clinical context, these findings are consistent with the typical demyelinating and axonal pathophysiology of median neuropathy in carpal tunnel syndrome (CTS). 2. There is no evidence of cervical radiculopathies, brachial plexopathies, focal left median, bilateral radial or ulnar neuropathies in their elbow or wrist segments, upper limbs polyneuropathies or myopathies.

December 4, 2012: Follow up Evaluation. EMG review. Assessment: Hypertrophic keloid scar status post right volar carpal ganglion excision. Right carpal tunnel syndrome. Plan: Recommended carpal tunnel release with scar revision and multilayer closure.

January 9, 2013: Follow up Evaluation. Pre-op visit. Claimant presented with nerve conduction study interpretation reveals moderate-to-severe right carpal tunnel syndrome because of the active denervation of the abductor pollicis brevis, not simply based on the active denervation of the APB. If claimant continues to

have paresthesias in the median distribution despite conservative care. The claimant also continues to have a great deal of pain over her hypertrophic scar with radiation to the superficial radial nerve. Medications: Lyrica 75mg, Ibuprofen. Physical examination: The claimant has significantly hypertrophic keloid over the longitudinal incision as noted before over the volar, radial side of the right wrist. Tinel's over the scar causes a radiation in the radial nerve distribution. Strongly positive Tinel's test, Phalen's test and median nerve compression test with decreased sensation noted in the median nerve distribution. Mild weakness of the abductor pollicis brevis is noted. Plan: Recommend carpal tunnel release with scar revision and multilayer closure.

May 24, 2013: Designed Doctor Evaluation. Results of examination: The claimant's problem has progressed from the last examination. The right wrist grossly reveals that the claimant has a keloid scar over the distal part of the radius volar surface. The keloid was about the size of a pea and now the keloid involves the entire incision of about an inch, exquisitely tender to light touch like clothing and that gives the claimant paroxysms of pain the her wrist on the volar aspect. Claimant also has a moderately positive Phalens's test. Was not able to do the Tinel's test because it is so tender in that area. Range of motion in wrist is fine. Claimant has appropriate deviation, flexion and extension, but a positive Phalen's test. Diagnosis: Status post wrist sprain/strain. Status post multiloculated ganglion cyst of the wrist and Madulung's deformity. In addition, claimant has a diagnosis with EMG evidence of carpal tunnel syndrome and hypertrophic keloid scar.

July 11, 2013: Evaluation. Claimant presented with continued complaints of right hand dysesthesias and right wrist pain. Physical exam: Examination of the right hand and wrist reveals a healed, hypertrophic very sensitive scar over the volar radial aspect of the right wrist. No recurrent gauglion cyst is noted. There is a positive Tinel's test in the area of the scar. Sensation is diminished in the median nerve distribution with a positive Tinel's, Phalen's, and median nerve compression test. No atrophy is noted but there is weakness of the abductor pollicis brevis. Plan: opined that he suspected the claimant's ongoing carpal tunnel syndrome had worsened since the carpal ganglion excision and that she may have a posttraumatic post-surgical neuroma in the area of the scar. He stated the EMG emonstrated median nerve compression with active APB denervaton. He also reported the claimant's work comp carrier had finally covered her problems and so he now wanted to proced with surgical treatment with keloid excision, tenolysis, possible neuroma excision and median nerve decompression.

July 18, 2013: UR performed. Rationale for Denial: She presented on 07/11/13 with right hand dysesthesia and right wrist pain. She was taking one to two tablets of meloxicam 7.5 mg once daily, Lyrica 75 mg twice daily, and Norco 5-325 mg every eight hours on an as needed basis for pain. Examination of the right hand/wrist showed a healed hypertrophic scar over the volar right wrist: no recurrent ganglion cyst: weakness of the abductor pollicis brevis: impaired sensation over the median nerve distribution: and positive Tinel's, Phalen's, as well as median nerve compression tests. There is no current clinical finding for a

cutaneous neuroma to justify an excision procedure. There is no mention of any abnormal Katz hand diagram score, nocturnal symptom, or Flick sign to support the presence of right carpal tunnel syndrome. The current degrees of ROM deficit were not stated in the 07/11/13 report to justify tenosynovectomy. It is not apparent in the review whether silicone sheets, compression garment, and steroid injections have been utilized as lower levels of care prior to this requested keloid scar excision, neuroma excision, and carpal tunnel release. The functional response to prior OT sessions was not stated to indicate failure of active therapy. The medical necessity of surgery cannot be validated at this time.

07/30/2013: UR performed. Rational for Denial: There is still no current clinical findings of a cutaneous neuroma to justify an excision. Moreover, the records still do not mention any abnormal Katz hand diagram score, nocturnal symptom or Flick sig to support the presence of right carpal tunnel syndrome. The current degrees of ROM deficit were still not stated to justify tenosynovectomy. There is still no mention of any previous use of silicone sheets, compression garment, and steroid injection as lower levels of care. The functional response to prior OT sessions was still not reported in indicate failure of active therapy. In agreement with the prior determination, the medical necessity of surgery has still not been validated.

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

The previous adverse determinations are partially overturned. The EMG/NCS performed on November 27, 2012 revealed evidence of mild-moderate right median neuropathy at the wrist that affected both sensory and motor fibers, without definite conduction block or loss of sensory axons, but with APB active denervation on needle EMG. Those findings were consistent with the typical demyelinative and axonal pathophysiology of median neuropathy in carpal tunnel syndrome (CTS). The most recent physical exam findings documented on July 11, 2013 included diminished sensation in the median nerve distribution with a positive Tinel's, Phalen's, and median nerve compression test. No atrophy was noted but there was weakness of the abductor pollicis brevis. The clinical findings correlate with EMG/NCS findings and support the request for right carpal tunnel release 64721.

examination of the right hand and wrist on July 11, 2013 also revealed a healed, hypertrophic very sensitive scar over the volar radial aspect of the right wrist. There was a positive Tinel's test in the area of the scar as well. This was consistent with the findings on May 24, 2013 who found the right wrist to grossly reveal a keloid scar over the distal part of the radius volar surface. The keloid was about the size of a pea on his first examination and reported that now the keloid involved the entire incision of about an inch, was exquisitely tender to light touch like clothing and that it gave the claimant paroxysms of pain the her wrist on the volar aspect. Therefore, there is enough documentation to support a keloid excision 11400, 15002 and 12041.

There is no documentation of limited wrist flexion or extension consistent with FCR adhesions and no MRI revealing neuroma. There was no local administration to delineate if the diagnosis of neuroma is even accurate. Therefore, FCR Tenolysis w/Layered Closure and Right Wrist Neuroma Excision 25295 and 64774 are not indicated at this time.

Again, the request for Rt Wrist Neuroma Excision, RCT release 64721, 25295, 64774, 15002, 11400, 12041 RUSH:OP:Rt Keloid Excision & FCR Tenolysis w/Layered Closure is partially overturned. The request for RCT release and Rt Keloid Excision is found to be medically necessary and the request for Rt Wrist Neuroma Excision and FCR Tenolysis w/Layered Closure if not found to be medically necessary.

ODG Guidelines:

The Official Disability Guidelines Treatment in Workers' Compensation does not specifically address the request for Keloid Scar Excision with multilayer closure and Excision cutaneous neuroma of the wrist.

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](#))

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)**