



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**Date notice sent to all parties:** 6/10/2013

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of an OP Right Wrist Carpal Tunnel Release / Hardware Removal.

**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.

**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 OP Right Wrist Carpal Tunnel Release / Hardware Removal.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed:

Denial Letters – 4/1/13, 5/3/13

Office Notes – 3/1/13, 4/9/13

Patient Information Sheet – 3/27/13

Progress Notes – 2/15/12, 4/18/12, 10/29/12, 11/28/12, 3/27/13

Order Requisition – 2/15/12

Clarification Request Letter – 10/25/12  
Utilization Review Referral – 3/27/13

NCS and Electromyography Report – 8/14/12

DDE Report – 9/10/12

Fluoroscopic Guidance Arthrogram Right Wrist Report – 3/19/12  
CT Arthrogram Right Wrist – 3/19/12

Operative Report – 4/27/11  
WC69 – 9/20/10

DDE Report – 9/20/10

Schedule Note – 3/6/12

Records reviewed:

Letter to patient – 5/28/13  
Appeal for Reconsideration – 4/16/13  
Patient Medical History – 10/29/12  
LHL009 – 5/28/13

Acknowledgement of Reconsideration Request – 4/18/13

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The fell off a 3 step ladder on the date of injury, sustaining a distal radius fracture. The claimant underwent an open reduction and internal fixation of the fracture on 10/20/09. The claimant developed post traumatic arthroplasty and underwent a wrist fusion on 4/2/11. This claimant has had persistent right wrist pain, numbness, tingling, nocturnal awakening and dexterity issues involving the right wrist, since the date of injury. Treatments have included restricted activities, an initially successful cortisone injection, splinting and medications. CT arthrogram revealed a dorsal fixation plate, a potentially non-fixated screw and wrist fusion. Diagnoses include retained hardware and carpal tunnel syndrome. An 8/14/12 dated electrical study of the right upper extremity was noted to be normal. The most recent clinical record was the appeal dated 4/9/13, which noted that the carpal tunnel symptoms have been noted to be persistent and progressive. A prior 3/1/13 dated appeal letter noted the positive Flick sign, positive carpal compression and Tinel's sign, along with increased nocturnal symptoms. Denial letters discussed the lack of objective findings of carpal tunnel syndrome on examination and incomplete guideline criteria of failed non-operative treatments.

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

The claimant has documented painful wrist hardware that is now redundant, as the wrist has been fused surgically. In addition, the claimant has evidence of both progressive subjective and (more recently) positive objective clinical signs of carpal tunnel syndrome. The negative electrodiagnostic test can be considered to plausibly have been adversely affected (and hence unreliable) by prior treatments and/or is simply just negative, a not uncommon occurrence. The trial and failure of extensive non-operative treatments has been well documented. The referenced guidelines support the requests as being reasonable and medically necessary as the intent and aggregate of criteria have been met.

**ODG Wrist Chapter-Hardware Removal:**

Not recommend the routine removal of hardware implanted for fracture fixation, except in the case of broken hardware or persistent pain, after ruling out other causes of pain such as infection and nonunion. Not recommended solely to protect against allergy, carcinogenesis, or metal detection. Recommend removal of hardware when fractures are not involved, the pins are stabilizing a joint while a ligament or tendon repair is healing and the must be removed so that the joint can resume function, for example, a pin in the dip joint of a finger to stabilize while an extensor tendon is healing in place or in the wrist to stabilize carpal bones while a scapholunate or other ligament reconstruction is healing. Although hardware removal is commonly done, it should not be considered a routine procedure. The decision to remove hardware has significant economic implications, including the costs of the procedure as well as possible work time lost for postoperative recovery, and implant removal may be challenging and lead to complications, such as neurovascular injury, refracture, or recurrence of deformity. Current literature does not support the routine removal of implants to protect against allergy, carcinogenesis, or metal detection. (Busam, 2006) Despite advances in metallurgy, fatigue failure of hardware is common when a fracture fails to heal. Revision procedures can be difficult, usually requiring removal of intact or broken hardware. (Hak, 2008) Following fracture healing, improvement in pain relief and function can be expected after removal of hardware in patients with persistent pain in the region of implanted hardware, after ruling out other causes of pain such as infection and nonunion. (Minkowitz, 2007)

**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

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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)**