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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 12/15/14

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a repeat carpal tunnel release surgery.

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 a repeat carpal tunnel release surgery.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

Clinical records were reviewed, including from the treating provider. Clinical and electrical study findings revealed bilateral carpal tunnel syndrome, in xxxx. In September 2012, she underwent bilateral carpal tunnel releases per another provider. Documentation from July 15, 2014 described that the numbness had improved but there was persistent pain in the hands. Recurrent numbness was

also described with certain activities. Pain has reportedly resulted in decreased grip strength. Nocturnal pain has also been described. Exam findings have included a positive Tinel sign and grip strength has been 4/5. Electrical studies were noted to reveal a moderately severe carpal tunnel syndrome compared to mild on the right side. Treatment with oral cortisone was noted to have failed. Subsequent records have included from September 9, 2014 in which symptoms continued. Numbness was noted in the distribution of the median nerve, along with a positive Phalen sign. Postoperative treatment since the initial carpal tunnel release was unclear, per denial letters. Actual wearing of prescribed splints and/or the outcome of same was noted to be unclear. According to the carrier reviewer doctors, there was no documented evidence of treatment with therapy or cortisone injection.

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

There is evidence of left-sided carpal tunnel syndrome that has been resistant to prior surgery, restricted activities and medications. The subjective and objective findings do correlate with the positive electrical studies (that are significantly worse on the left side as compared to the right.) It is improbable that any other type of non-operative treatment would have any significant efficacy in this well-established diagnosis. The overall intent of clinical guidelines referenced below therefore do support the request as being medically reasonable and necessary based upon the patient's presentation.

Reference: ODG Carpal Tunnel Syndrome Chapter

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)