

IRO NOTICE OF DECISION – WC



Notice of Independent Review Decision

January 15, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right carpal tunnel release

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

American Board of Orthopaedic 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 of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- 8-22-12, office visit.
- 9-19-12, office visit.
- 10-10-12, office visit.
- 12-14-12, office visit.
- 2-20-13, office visit.
- 3-20-13, office visit.
- 5-17-13, office visit.
- 6-28-13, office visit.
- 7-19-13, office visit.
- 8-13-13, office visit.
- Orthopaedic: Medication List: Cymbalta 60mg, Ibuprofen 800mg, Tramadol 50mg, and Flexeril 5mg.
- 8-30-13, office visit.
- 9-4-13, office visit.
- 10-2-13, office visit.
- 10-11-13, office visit.
- 11-6-13, office visit.
- 11-8-13, office visit.
- 11-18-13 Fax cover sheet.
- 11-21-13 Utilization Review Determination.
- 12-1-13, office visit.
- 12-11-13 Fax cover sheet.
- 12-19-13 Utilization Review Determination.
- 12-24-13 Request form: Request for a review by an Independent Review Organization.

- 12-30-13 Fax cover sheet.
- Fax cover sheet.
- Independent Review Portal-IRO Request Details: Your Request has been successfully submitted.
- 12-30-13 Department of Insurance: Notice to Claims Eval of Case Assignment.
- Fax cover sheet.
- 12-30-13 Department of Insurance: Notice to Utilization Review Agent of Assignment to Independent Review Organization.
- 12-30-13 Department of Insurance: Notice of Assignment to Independent Review Organization: Assignment of Case.
- 12-30-13 Fax cover sheet.

PATIENT CLINICAL HISTORY [SUMMARY]:

8-22-12, the claimant complains of right sided rib fracture and ongoing chronic right sided chest pain. The claimant had his injury on xx/xx/xx. The claimant fell striking his chest. The claimant sustained fractures to ribs 5, 6, 7 and 8. Plan: The evaluator recommended work hardening. The evaluator is going to refill his NSAIDS at this visit.

Follow-up visit on 9-19-12 notes the claimant was prescribed Ibuprofen. The claimant is to continue work conditioning.

Follow-up visit on 10-10-12 notes the evaluator recommended pain management consult.

12-14-12, the claimant is status post rib fracture. Diagnosis: Right chest wall sympathetic dystrophy after well healed rib fracture about a year ago. Plan: Continue medications. Continue seeing. The claimant was prescribed Duexis.

2-20-13, the claimant complains of thoracic reflex sympathetic dystrophy. Diagnosis: Right thoracic reflex sympathetic dystrophy. Plan: The evaluator refilled Nexium, Flexeril and Motrin. The claimant is ordered to get a cervical MRI.

3-20-13, the claimant complains of right chest, thoracic reflex sympathetic dystrophy. Diagnosis: Thoracic reflex sympathetic dystrophy. Plan: The claimant is to follow-up. The evaluator will try modalities of physical therapy.

5-17-13, the claimant complains of right chest wall sympathetic dystrophy. Diagnosis: Thoracic-chest wall reflex sympathetic dystrophy. Plan: The evaluator refilled Nexium and Ibuprofen. The claimant is to follow-up and gets stimulator.

6-28-13, the claimant complains of thoracic pain and chronic intractable pain syndrome. The claimant is status post dual lead spinal cord stimulator trial on 6-24-13. The claimant will wait until visit to decide whether he would like to proceed with permanent placement. Assessment: Thoracic pain, possible complex regional pain syndrome and neuropathic pain of the chest wall, chronic pain, long-term use of medications, history of rib fractures. Plan: The claimant was encouraged to keep his follow-up appointment for removal of leads.

7-19-13, the claimant returned for follow-up on right side of chest and back, right rib pain. The claimant fell on xx/xx/xx and fractured his ribs 5, 6, 7, 8. Despite healing these displaced fractures he developed a debilitating severe right chest wall sympathetic dystrophy. Assessment: Right reflex sympathetic dystrophy of the upper limb, ribs, fracture, closed. Plan: The evaluator order EMG-NCV. The claimant has numbness and tingling, of his right hand with generalized weakness.

8-13-13, the claimant complains of numbness in right hand. Assessment: Carpal tunnel syndrome, mild CTS right hand no other findings. Plan: The evaluator order EMG of the upper extremity.

Orthopaedic: Medication List: Cymbalta 60mg, Ibuprofen 800mg, Tramadol 50mg, and Flexeril 5mg.

8-30-13, the claimant returned for follow-up on right side of chest and back, right rib pain. Assessment: Right reflex sympathetic dystrophy of the upper limb, ribs, fracture, closed, carpal tunnel syndrome. Plan: For carpal tunnel syndrome will utilize a night time wrist splint.

9-4-13, the claimant complains of right side back and arm pain. He did undergo a procedure recently. His last procedure was on 7-8-13. The patient reports 40% improvement in his pain score. Assessment: Long term drug use, chronic pain syndrome, myofascial pain, sprains and strains of back; thoracic, generalized pain, rib(s), fracture, closed, reflex sympathetic dystrophy. Plan: The claimant was referred to psychologist. The evaluator discussed placement of the P-STIM. Continue opioid therapy. The evaluator recommended active rehabilitation along with injection therapy.

10-2-13, the claimant complains of chest, right side back and right arm pain. Assessment: Long term drug use, chronic pain syndrome, myofascial pain, sprains and strains of back; thoracic, generalized pain, rib(s), fracture, closed, reflex sympathetic dystrophy. Plan: The claimant was prescribed Omeprazole, Gabapentin, Ibuprofen, Ointment 60 Keto10%-gab6%, Tramadol, and Nexium. The

evaluator discussed placement of the P-STIM. Continue opioid therapy. The evaluator believes that patients with chronic pain do well with regular aerobic/water exercise and very light weighty lifting.

10-11-13, the claimant returned for follow-up on right side of chest and back, right rib pain. Assessment: Right reflex sympathetic dystrophy of the upper limb, ribs, fracture, closed, carpal tunnel syndrome. Plan: Asp-inj inermidate-dexamethasone.

11-6-13, the claimant complains of back, right arm, chest and right upper extremity pain. P-STIM was denied. SCS trial was unsuccessful. UDS will be collected today. Assessment: Long term drug use, chronic pain syndrome, myofascial pain, sprains and strains of back; thoracic, generalized pain, rib(s), fracture, closed, reflex sympathetic dystrophy. Plan: Percutaneous implantation of neurostimulator electrode array, epidural. IPG permanent placement.

11-8-13, the claimant returned for follow-up on right side of chest and back, right rib pain. The claimant states his symptoms have worsened. Assessment: Right reflex sympathetic dystrophy of the upper limb, ribs, fracture, closed, carpal tunnel syndrome. Plan: The evaluator will submit for surgery. Preop labs needed for medical necessity or carpal release.

11-18-13 Fax cover sheet: Orthopaedic; to: UR Department; Requesting authorization for right carpal tunnel release-outpatient.

11-21-13 Treatment requested: Right carpal tunnel release. The authorization request of right carpal tunnel release was reviewed by a physician advisor, orthopedic surgery, Sports Medicine, who determined that it does not meet medical necessity guidelines. Advised of reconsideration rights. It was noted that there is no documentation of convincing physical examination objective findings to support the requested procedure.

12-1-13, the claimant returned for follow-up on right side of chest and back, right rib pain. Assessment: Right reflex sympathetic dystrophy of the upper limb, ribs, fracture, closed, carpal tunnel syndrome. Plan: The claimant has failed all forms of conservative treatment for CTS. Carpal tunnel release is the appropriate next step.

12-11-13 Fax cover sheet: Orthopaedic; to: UR Appeal; Requesting appeal for right carpal tunnel release-outpatient.

12-19-13 An appeal of the UR denial determination issued on 11-21-13, for the treatment requested was received on 12-11-13. It was determined that it does not meet medical necessity guidelines. The right carpal tunnel release that was requested has been reviewed by a Physician Advisor who was not involved at the initial review, Orthopedic Surgery, TX LIC who holds a professional (fertilization in a health care specialty appropriate in the type or health care that the injured employee is receiving. A dentist licensed in Texas performs dental health care reviews. As the

requesting provider, you were provided a reasonable opportunity to speak with the Physician Advisor regarding your request prior to this determination being rendered. Conclusion: The request for right carpal tunnel release is non-certified. It was noted that the claimant does not meet criteria to include provocative exam findings indicating the patient confirmation of carpal tunnel syndrome.

12-24-13 Request form: Request for a review by an Independent Review Organization.

12-30-13 Fax cover sheet: Department of Insurance Ref: IRO Notice Assignment (IRO).

Fax cover sheet: to: Department of Insurance HWCN Division;

Independent Review Portal-IRO Request Details: Your Request has been successfully submitted.

12-30-13 Department of Insurance: Notice to Claims Eval of Case Assignment.

Fax cover sheet: to: Claims Eval;

12-30-13 Department of Insurance: Notice to Utilization Review Agent of Assignment to Independent Review Organization: In accordance with Texas Insurance Chapter (TIC). 4201 and TDI rules, the carrier, if applicable, or the utilization review agent (URA) must provide to the Independent Review Organization the information or documents listed below no later than the time frame required. Any medical records of the enrollee that is relevant to the review. Any documents used in making the adverse determination. Copies of the adverse determination and the resolution of the appeal. Any documents and other' written information submitted in support of the appeal. A list of each physician or health care provider who has provided care to the patient and who may have medical records relevant to the review and Workers Compensation Only Guidelines, policies, protocols and criteria used by the insurance carrier or the URA in making the decision.

12-30-13 Department of Insurance: Notice of Assignment to Independent Review Organization:

12-30-13 Fax cover sheet: Department of Insurance to: Ref: IRO Notice Assignment (URA-IC).

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

Medical records reflect a claimant with mild carpal tunnel syndrome to the right. Current evidence based medicine reflects that carpal tunnel release is recommended after an accurate diagnosis of moderate or severe CTS. The

claimant does not have positive physical exam findings documented as required per ODG. Therefore, the request for right carpal tunnel release is not reasonable or medically necessary.

Per ODG 2013 Carpal tunnel release: Recommended after an accurate diagnosis of moderate or severe CTS. Surgery is not generally initially indicated for mild CTS, unless symptoms persist after conservative treatment. See [Severity definitions](#). Carpal tunnel release is well supported, both open and endoscopic (with proper surgeon training), assuming the diagnosis of CTS is correct. (Unfortunately, many CTR surgeries are performed on patients without a correct diagnosis of CTS, and these surgeries do not have successful outcomes.) Outcomes in workers' comp cases may not be as good as outcomes overall, but studies still support the benefits from surgery. Carpal tunnel syndrome may be treated initially with education, activity modification, medications and night splints before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits), but outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases. Nevertheless, surgery should not be performed until the diagnosis of CTS is made by history, physical examination and possible electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis, however the benefit from these injections although good is short-lived. Surgical decompression of the median nerve usually has a high rate of long-term success in relieving symptoms, with many studies showing success in over 90% of patients where the diagnosis of CTS has been confirmed by electrodiagnostic testing. (Patients with the mildest symptoms display the poorest post-surgery results, but in patients with moderate or severe CTS, the outcomes from surgery are better than splinting.) Carpal tunnel syndrome should be confirmed by positive findings on clinical examination and may be supported by nerve conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. Positive EDS in asymptomatic individuals is not CTS. Any contributions to symptoms by cervical radiculopathy (double crush syndrome) will not be relieved by the surgery. ([Various references listed under "Surgical Considerations"](#)) ([Chung, 1998](#)) ([Verdugo, 2002](#)) ([Shin, 2000](#)) ([AHRQ, 2003](#)) ([Lyll, 2002](#)) ([Gerritsen-JAMA, 2002](#)) ([Verdugo-Cochrane, 2003](#)) ([Hui, 2004](#)) ([Hui, 2005](#)) ([Bilic, 2006](#)) ([Atroshi, 2006](#)) ([Ucan, 2006](#)) Being depressed and a workers' compensation claimant predicts being out of work after carpal tunnel release surgery. This highlights the importance of psychosocial management of musculoskeletal disorders. ([Amick, 2004](#)) ([Karjalainen-Cochrane, 2002](#)) ([Crossman, 2001](#)) ([Denniston, 2001](#)) ([Feuerstein, 1999](#)) Older age should not be a contraindication to CTR. ([Weber, 2005](#)) ([Hobby2, 2005](#)) In a sample of patients aged 70 years and older, patient satisfaction was 93 percent after surgical treatment versus 54 percent after nonsurgical treatment. ([Ettema, 2006](#)) Mini palm technique may be as good or better than endoscopic or open release. ([Melhorn, 1994](#)) ([Cellocco, 2005](#)) Steroid injections and wrist splinting may be effective for relief of CTS symptoms but the benefit decreases over time. Symptom duration of less than

3 months and absence of sensory impairment at presentation are predictive of an improved response to conservative treatment. Selected patients presenting with mild to moderate carpal tunnel syndrome (i.e., with no thenar wasting or obvious underlying cause) may receive either a steroid injection or wear a wrist night splint for 3 weeks. This will allow identification of the patients who respond well to conservative therapy and do not need surgery. ([Graham, 2004](#)) ([Ly-Pen, 2005](#)) See [Injections](#). While diabetes is a risk factor for CTS, patients with diabetes have the same probability of positive surgical outcome as patients with idiopathic CTS. ([Mondelli, 2004](#)) Statistical evaluation identified five factors which were important in predicting lack of response to conservative treatment versus surgery: (1) age over 50 years; (2) duration over ten months; (3) constant paresthesia; (4) stenosing flexor tenosynovitis; & (5) a Phalen's test positive in less than 30 seconds. When none of these factors was present, 66% of patients were improved by medical therapy, 40% were improved with one factor, 17% were improved with two factors, and 7% were improved with three factors, and no patient with four or five factors present was cured by medical management. ([Kaplan, 1990](#)) Operative treatment was undertaken for 31% of new presentations of carpal tunnel syndrome in 2000. ([Latinovic, 2006](#)) In the treatment of carpal tunnel syndrome, decompression surgery produces a better long-term outcome than local corticosteroid injections, according to data presented at the American College of Rheumatology meeting. At 1 year, the results showed that local corticosteroid injection was as effective as decompression surgery; however, at 7 years, the estimated accumulated incidence of therapeutic failure in the corticosteroid group was 41.8% compared with 11.6% in the surgery group, because the effects of corticosteroid injections fade with time. ([Ly-Pen, 2007](#)) This RCT concluded that patients with CTS who do not have satisfactory improvement with nonsurgical treatment should be offered surgery. Symptoms in both groups improved, but surgical treatment led to better outcome than did non-surgical treatment. However, the clinical relevance of this difference was modest. ([Jarvik, 2009](#)) This systematic review found that the recent literature demonstrates a trend toward recommending early surgery for CTS cases with or without median nerve denervation. ([Bernardino, 2011](#)) Despite the fact that symptoms are impaired in diabetic patients with CTS compared with non-diabetic patients with CTS, diabetic patients experience similar symptomatic and functional benefits from carpal tunnel release as do non-diabetic patients. ([Thomsen, 2010](#)) In this meta-analysis, there were no statistically significant differences between surgical release and conservative management at 3 months, but there was a benefit in favor of surgery in terms of function (0.35) and symptom relief (0.37) at 12 months, and at 6 months. The RR of normal nerve conduction studies after surgery was 2.3 compared to conservative treatment, while the RR was 2.03 for complications. The authors concluded that the evidence supports surgical release for severe symptoms, and a short trial of conservative management with surgical release recommended for persistent symptoms after the trial. ([Shi, 2011](#))

Adjunctive procedures: The 2008 AAOS CTS clinical treatment guidelines concluded that surgeons not routinely use the following procedures when performing carpal tunnel release: Skin nerve preservation; & Epineurotomy. The following procedures

had no recommendation for or against their use: Flexor retinaculum lengthening; Internal neurolysis; Tenosynovectomy; & Ulnar bursa preservation. ([Keith, 2010](#))

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](#))

IRO REVIEWER REPORT - WC

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)**