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November 30, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right endoscope carpal tunnel release and right cubital tunnel release

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

Orthopedic Physician

REVIEW OUTCOME:

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

Upheld (Agree)

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a right hand dominant female who developed right elbow pain due to prolonged data entry work.

On xxxx, evaluated the patient for right elbow pain and numbness. It was noted the patient had previously been diagnosed with right subluxating ulnar nerve at the elbow and carpal tunnel syndrome (CTS) causing pain and numbness in the hand. The patient had electrodiagnostic study on February 13, 2004, that showed slowing of the ulnar nerve at the elbow. She stated her hand was mostly numb at night, which awakened her from sleep. She described her pain at 8/10 on the pain scale and experienced pain and numbness while talking on the phone and applying makeup. She also had difficulty opening jars. History was significant for migraine headaches, acid reflux, seasonal allergies and irritable bowel syndrome. On examination of the right wrist compression test was positive in the right wrist, Phalen's test was positive on the right. The diagnoses were cubital

tunnel syndrome and CTS. recommended obtaining an electromyography/nerve conduction velocity (EMG/NCV) study and if positive, the patient could be considered for a cubital tunnel release, ulnar nerve release and an endoscopic carpal tunnel release (CTR) with possible forearm fasciotomy.

Electrodiagnostic studies of the upper extremities on July 9, 2015, demonstrated isolated findings that appeared to indicate moderate right median sensorimotor neuropathy at the wrist as seen in CTS with conduction block or sensory axons and right APB chronic axon loss. There was evidence suggestive for very mild right ulnar neuropathy at the elbow. The short segmental NCS demonstrated focal motor conduction slowing at the retro-epicondylar ulnar groove in the 2 cm segment just proximal to the medial humeral condyle. There was no evidence of cervical radiculopathy, brachial plexopathy, upper limbs large fiber polyneuropathy, neuromuscular transmission defects or myopathy. The study was interpreted.

On July 28, 2015, the patient presented to a follow-up of her EMG/NCV study. The study was interpreted as showing moderate right median sensorimotor neuropathy and a mild right ulnar neuropathy at the elbow. The patient stated her symptoms had not changed. She felt weakness in the right as well as numbness in all fingers. recommended endoscopy right CTR and endoscopic-assisted cubital tunnel release.

On August 21, 2015, the request for right endoscopic CTR and right cubital tunnel release with possible ulnar nerve transposition was non-authorized. Analysis and clinical basis for conclusion: *"The clinical documentation submitted for review failed to indicate the patient had 2 symptoms including an abnormal Katz hand diagram score, nocturnal symptoms or a Flick sign. There was a documentation indicating the patient had a positive compression test and Phalen's test. The patient had positive NCV findings. However, there was a lack of documentation indicating recent conservative care including three of the following: Activity modification, night wrist splinting, nonprescription analgesia, and home exercise training. The request for a right endoscopic carpal tunnel release is non-certified. Regarding the request for right cubital tunnel release and possible ulnar nerve transposition, there was a lack of documentation indicating the patient had recent conservative care including exercise, activity modification, medications, and padding and splinting. Additionally, there was a lack of documentation indicating the patient had the ulnar nerve subluxation on range of motion of the elbow. The request for a right cubital tunnel release with possible ulnar nerve transposition is not certified Peer to peer contact was not successful. Given the above, the request for right endoscopic carpal tunnel release & right cubital tunnel release with possible ulnar nerve transposition CPT 29848, 64718 is non-certified."*

On September 14, 2015, the reconsideration request for right endoscopic carpal tunnel release and right cubital tunnel release with possible ulnar nerve transposition CPT-29848, 64718 was non-authorized, as it did not meet necessity guidelines. Rationale: *"The request for a Right Endoscopic Carpal Tunnel Release and Right Cubital Tunnel Release with Possible Ulnar Nerve Transposition CPT-29818, 64718 had been previously denied due to lack of documentation regarding conservative care. Based on the clinical information submitted for review and the Official Disability*

Guidelines, the request is not supported. It was noted the patient had a positive Phalen's and positive compression test with positive EMG/NCV findings. There was also no documentation of conservative treatment to include exercise, activity modification, splinting, and medications including NSAIDs. In addition, there was no evidence the patient had an ulnar nerve subluxation on range of motion of the elbow. The reviewer spoke with X who stated the patient has nocturnal symptoms and a positive flick sign. Also stated history of conservative treatments including steroid injections to wrist and elbow, NSAIDs, and splinting of wrist and elbow. However, documentation of conservative care was not submitted after peer-to-peer discussion. As such, the request for a right endoscopic carpal tunnel release and right cubital tunnel release with possible ulnar nerve transposition is noncertified."

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

The claimant in this case does in fact have documented clinical findings of carpal tunnel syndrome with positive electrodiagnostic testing confirming the diagnosis of a moderate degree, and on exam positive Tinel and Phalen at the wrist. Lacking however is any information with respect to conservative care in the more recent timeframe inclusive of carpal tunnel injection, splinting, antiinflammatory medications, and therapy or a home exercise program. Absent conservative care the guidelines would not support a need for an endoscopic carpal tunnel release. With respect to cubital tunnel release and ulnar nerve transposition, electrodiagnostic findings were mild in nature and there was not documentation of ulnar nerve subluxation on exam; additionally there was not documentation of recent conservative care consisting of splinting, activity modification, therapy or home exercise program. Absent documentation of any recent conservative care, the request for cubital tunnel release with possible ulnar nerve transposition is not supported as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines (20th annual edition), 2015, chapter carpal tunnel syndrome

Carpal tunnel release surgery (CTR)

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)

Official Disability Guidelines (20th annual edition), 2015, chapter elbow

Surgery for cubital tunnel syndrome (ulnar nerve entrapment)

Recommended as indicated below (simple decompression in most cases). Surgical transposition of the ulnar nerve is not recommended unless the ulnar nerve subluxes on ROM of the elbow.

ODG Indications for Surgery -- Surgery for cubital tunnel syndrome: Initial conservative treatment, requiring ALL of the following:

- Exercise: Strengthening the elbow flexors/extensors isometrically and isotonicly within 0-45 degrees

- Activity modification: Recommend decreasing activities of repetition that may exacerbate the patient's symptoms. Protect the ulnar nerve from prolonged elbow flexion during sleep, and protect the nerve during the day by avoiding direct pressure or trauma.

- Medications: Nonsteroidal anti-inflammatory drugs (NSAIDs) in an attempt to decrease inflammation around the nerve.

- Pad/splint: Use an elbow pad and/or night splinting for a 3-month trial period. Consider daytime immobilization for 3 weeks if symptoms do not improve with splinting. If the symptoms do improve, continue conservative treatment for at least 6 weeks beyond the resolution of symptoms to prevent recurrence.