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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** February 4, 2016

**IRO CASE #:**

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

Left carpal tunnel release (64721).

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

M.D., 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 requested left carpal tunnel release (64721) is not medically necessary.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who sustained an industrial injury on XX/XX/XX. The mechanism of injury was documented as repetitive use as a manual laborer. Past surgical history was positive for right carpal tunnel release in XX/XXX. The XX/XX/XX treating provider report documented increasing left wrist pain over the past XX years since his right carpal tunnel release. The patient reported that he woke up with numbness in his three middle findings. His pain was increased in the afternoons at work. He was taking ibuprofen. Physical exam documented positive Phalen's and Tinel's signs on the left. Tramadol was prescribed and he was referred to orthopedics. The XX/XX/XX orthopedic report cited left hand numbness and tingling with some weakness and paroxysmal pain. Current medications included ibuprofen. Physical exam documented no neck

pain or cervical radiculopathy, full bilateral shoulder and elbow range of motion, full bilateral wrist range of motion, and full range of motion of all digits. The hands were soft and warm with normal color and cascade. Tinel's sign and median nerve compression tests were negative on the right, and mildly positive on the left. There was no evidence of cubital tunnel or pronator syndrome. There were no radiographs, nerve conduction velocity testing or laboratory work-up provided. The patient had evidence of carpal tunnel syndrome. Authorization was requested for left carpal tunnel release.

The URA indicates that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. The denial letter dated XX/XX/XX indicates left carpal tunnel release is not medically necessary based on a paucity of information regarding conservative care and absence of electrodiagnostic studies confirming carpal tunnel syndrome.

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

The Official Disability Guidelines (ODG) recommend carpal tunnel release surgery after an accurate diagnosis of moderate or severe carpal tunnel syndrome. Surgery is not generally initially indicated for mild carpal tunnel syndrome, unless symptoms persist after conservative treatment. Guidelines provide clinical indications for carpal tunnel release that include specific symptoms (abnormal Katz hand diagram scores, nocturnal symptoms, and/or Flick sign), physical exam findings (compression test, monofilament test, Phalen's sign, Tinel's sign, decreased 2-point discrimination, and/or mild thenar weakness), conservative treatment (activity modification, night wrist splint, non-prescription analgesia, home exercise training), successful corticosteroid injection trial, and positive electrodiagnostic testing. In this case, the ODG criteria have not been met. The patient presents with increasing left wrist pain with numbness, tingling, and weakness. Physical exam documented positive carpal tunnel provocative testing. There was no documentation of an electrodiagnostic study evidencing carpal tunnel syndrome. There was no documentation of a positive corticosteroid injection trial. In addition, detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, consistent with guidelines, and failure has not been submitted. Therefore, the requested left carpal tunnel release (64721) is not medically necessary.

In accordance with the above, I have determined that the requested left carpal tunnel release (64721) is not medically necessary for treatment of the patient's medical condition.

**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 JUDGMENT, 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)