ADVANCED
HAND&WRIST
SPECIALISTS

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Jacqueline Kurth, Manager
Medical Resource Office
Industrial Commission of Arizona
800 W. Washington Avenue, Suite 305
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Dear Jacquie:

This letter summarizes my opinions and recommendations regarding ODG Guidelines for Carpal Tunnel Syndrome (Treatment Chapter 3).

ODG treatment guidelines (with a few exceptions) are medically reasonable and appropriate for Arizona. Current Diagnosis and Treatment Guidelines from the American Academy of Orthopedic Surgeons (AAOS) are also relevant.

However, ODG does not distinguish between active care (improving and/or curing the condition) and supportive care (i.e. palliative care). Except in cases associated with pregnancy, carpal tunnel syndrome does not 'go away'. While many people will have waxing and waning symptoms over time, the underlying nerve compression continues to worsen. At this time, surgery is the only known treatment likely (in fact, highly likely) to resolve the condition.

Various therapies, medications, chiropractic, acupuncture, splints, lasers, other devices and exercises have not been shown to provide long term benefit. Wrist splints and corticosteroid injections are the only palliative treatments that have demonstrated short term benefit.

Since efficient claims processing is one goal, because limiting the time of exposure to health care is associated with higher rates of return to productivity and because palliative care can be provided effectively on a reduced schedule under supportive care, I believe that the most appropriate guidelines for Arizona, once diagnosis and causation have been established, may include the following:

> Initial treatment is conservative with night-time wrist neutral splinting with or without corticosteroid injection. Routine follow-up is indicated to determine effectiveness.
>
> If symptoms continue or recur, a second corticosteroid injection may be considered.

> If symptoms persist beyond seven weeks, surgical treatment is indicated. Pre-operative electrodiagnostic studies should be considered in all cases. If these are confirmatory, then the patient may be offered open or endoscopic carpal tunnel release.
>
> If the patient declines surgical treatment, then all further care is considered palliative and may be carried out on a supportive care basis with an appropriate rating of impairment.
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> Any patient with carpal tunnel syndrome and an electrodiagnostic study demonstrating a median mononeuropathy at the wrist is a candidate for carpal tunnel surgery. Such a patient who prefers to proceed with definitive surgical candidate may be offered surgery in lieu of initial conservative treatment.

ODG for post-operative care and return to work are appropriate for Arizona.

I believe it relevant to comment on some aspects of diagnosis. AAOS guidelines recommend that electrodiagnostic studies be performed prior to proceeding with surgery. These studies should be performed only by board certified neurologists or physical medicine specialists in our community. I see many cases of non-standard studies with non-standard interpretations by hand surgeons, orthopedists, primary care doctors and even therapists. These may be misleading and potentially harmful when they lead to unnecessary surgical intervention. The patients deserve the highest quality of care available in the community.

AAOS Guidelines also recommend against using MRI or ultrasound in the diagnosis of carpal tunnel syndrome at this time. While there may be indications for one or the other in select cases, they are not indicated in the majority of cases.

Finally, I want to express my concern regarding the peer review process. When well done, it can enhance the quality of care as well as claims processing. However, the peer review process in Arizona seems broken.

In the course of my clinical practice, as well as in my forensic practice, I have found that, in spite of the Commission's recommendations several years ago, many carriers are again using non-Arizona licensed doctors to perform these reviews. These reviewers are often non-same specialty certified. As an example. I had a 'peer-review' from a retired Missouri gynecologist regarding a complex wrist case. She asked me to explain the case in non-medical terms. They often have no records or have not reviewed any of the records and expect to have the entire history presented to them. They call the treating doctor's office expecting to discuss the case without regard for he doctor's schedule. If the call is not returned within a few hours, they 'non-certify'. If the treating doctor does return the call, the reviewer is often not available… and the treatment is 'non-certified'. If the treating doctor requests the reviewer's credentials, the reviewer often becomes hostile, resulting in 'non-certify'. Invariably, in the reviewer's report, all of this is blamed on the treating doctor.

As anyone can see, this delays care, causing frustration for and potential harm to the patient and adding to the frustration of managing a workers' compensation claim for the treating doctor.

I believe that injured Arizona workers are best served by peer-review when it is conducted by actively practicing Arizona-licensed physicians who are board-certified in the same specialty as the treating physician and who are also required to disclose their credentials without being asked. The carrier, not the treating physician, should be required to forward all records to the reviewer, who in turn should be required to have read and understood the records. The reviewer should schedule a mutually convenient time to discuss the case with the treating doctor in the event that a review and thorough understanding of the case does not already justify the recommended treatment. This will hold the reviewer to the high ethical standards of this community.

Thank you for allowing me to participate in this important process,

Sincerely,

Paul M. Guidera, M.D., FACS, CIME
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