

<b>Case Number:</b>	CM13-0011378		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	03/26/2012
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	07/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/08/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 56 year old female who reported an injury on 03/26/2012. The mechanism of injury was reported to be related to repetitive motion. Per the progress report dated 05/15/2013 the injured worker reported continuing neck pain, pain in her shoulders, and pain in her wrists and hands with numbness and tingling to the fingers, cramping, weakness, and dropping of objects. Per the electrodiagnostic testing dated 01/03/2013, the injured worker was reported to have evidence of moderate bilateral carpal tunnel syndrome. The injured worker was noted to have positive Phalen's and Tinel's test to bilateral wrist. Per the ultrasound of the bilateral wrists dated 01/08/2013, the injured worker was reported to have right fusiform enlargement of the median nerve, right normal first dorsal compartment, right normal common extensor tendons, right normal TFC, and normal left wrist. The request for authorization for medical treatment for the physical therapy and the cool care cold therapy for the right wrist was not provided in the documentation. The provider's rationale for the request was post surgery of the carpal tunnel of the right wrist. Previous treatments for the injured worker included physical therapy, medications and braces to the wrists.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**PHYSICAL THERAPY THREE TIMES FOUR VISITS FOR RIGHT WRIST:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 15-16.

**Decision rationale:** Per California Medical Treatment Utilization Schedule (MTUS) Guidelines, there was limited evidence demonstrating the effectiveness of physical or occupational therapy for carpal tunnel syndrome. The evidence may justify 3 to 5 visits over 4 weeks after surgery up to a maximum of 8 visits over 3 to 5 weeks with the treatment period of 3 months. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Therapy should include education in a home program, work discussion and suggestions for modifications, lifestyle changes, and setting realistic expectations. There was a lack of clinical findings regarding failed surgery to warrant the need for extended physical therapy sessions. There was a lack of documentation regarding the inclusion of a home exercise program in addition to the physical therapy. In addition, there was a lack of documentation regarding the surgery itself. Therefore, the request for physical therapy 3 times a week for 4 weeks for the right wrist is not medically necessary and appropriate.

**POSTOPERATIVE COOL CARE COLD THERAPY UNIT PLUS TECH FEE FOR THE RIGHT WRIST:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel, Continuous cold therapy (CCT).

**Decision rationale:** Per Official Disability Guidelines, continuous cold therapy is recommended as an option only in the postoperative setting, with regular assessment to avoid frostbite. Postoperative use generally should be no more than 7 days, including home use. There was a lack of documentation regarding the surgery and the intended use of the cold care unit. In addition, the request did not contain a timeframe for the use of the unit. Therefore, the request for postoperative cool care cold therapy unit plus tech fee for the right wrist is not medically necessary and appropriate.