

Case Number:	CM14-0181966		
Date Assigned:	11/06/2014	Date of Injury:	02/21/2014
Decision Date:	12/12/2014	UR Denial Date:	10/04/2014
Priority:	Standard	Application Received:	11/03/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This is a 31 year old patient with date of injury of 2/21/2014. Medical records indicate the patient is undergoing treatment for cervical radiculopathy, thoracic spine sprain/strain, lumbosacral radiculopathy, bilateral shoulder tendinitis/bursitis, right elbow tendinitis/bursitis, right elbow tendonitis/bursitis, left elbow and wrist compensable pain. Subjective complaints include neck, middle back and low back pain radiating into the upper and lower extremities with numbness and weakness, depression, anxiety, stress, sleep disorder, gastrointestinal discomfort due to medications. Objective findings include decreased grip strength on the right measured by a dynamometer and decreased sensation through C6-T1 on the right. Provocation tests for carpal tunnel syndrome were negative. Range of motion was intact bilaterally. Finkelstein's test was negative for tenosynovitis of the right thumb, hand and wrist. Treatment has consisted of physical therapy, muscle stimulation, therapeutic exercise, hot and cold packs. Radiographs of the right hand and wrist from 5/29/2014 revealed some reduced radiocarpal spacing. EMG from 09/29/2014 showed no electroneurographic evidence of entrapment neuropathy in the lower extremities. Electromyographic indicators of acute lumbar radiculopathy were not seen. The utilization review determination was rendered on 10/03/2014 recommending non-certification of 8 physio therapy visits for the right wrist and 1 ultrasound for the right wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 physio therapy visits visits for the right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy, Postsurgical Treatment Guidelines Page(s): 15-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, & Hand (Acute & Chronic), Physical/Occupational therapy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-278, Chronic Pain Treatment Guidelines Occupational Therapy and Physical Medicine Page(s): 74, 98-99, Postsurgical Treatment Guidelines Page(s): 15-16.

Decision rationale: MTUS Postsurgical Treatment Guidelines for Carpal Tunnel Syndrome cite "limited evidence demonstrating the effectiveness of PT (physical therapy) or OT (occupational therapy) for CTS (carpal tunnel syndrome). The evidence may justify 3 to 5 visits over 4 weeks after surgery . . ." MTUS continues to specify maximum of "3-8 visits over 3-5 weeks". MD Guidelines similarly report the frequency of rehabilitative visits for carpal tunnel (with or without surgical treatment) should be limited to a maximum of 3-5 visits within 6-8 weeks. The patient has already been certified for 18 occupational visits to treat the current injury; the requested number of session is in excess of the guidelines. As such, the request for 8 physiotherapy visits for the right wrist is not medically necessary.

1 ultrasound for the right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand, Ultrasound therapeutic

Decision rationale: ACOEM states "Limited studies suggest there are satisfying short- to medium-term effects due to ultrasound treatment in patients with mild to moderate idiopathic CTS, but the effect is not curative". ODG states concerning therapeutic ultra sound "Not recommended. In a Cochrane Database review, there was only weak evidence of a short-term benefit of therapeutic ultrasound for distal radial fractures." "The current guidelines and evidence based medicine do not recommend therapeutic ultrasound since the effectiveness of this therapy remains unproven. There is little evidence based medicine to support active therapeutic ultrasound vs. placebo ultrasound in treating musculoskeletal injuries or promoting soft tissue healing. As such, the request for 1 ultrasound for the right wrist is not medically necessary.