

Case Number:	CM14-0183770		
Date Assigned:	11/10/2014	Date of Injury:	12/23/2013
Decision Date:	12/12/2014	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	11/04/2014

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 Plastic and Reconstructive Surgery and is licensed to practice in Maryland, Virginia and North Carolina. 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 patient is a 35 year old female with a reported date of injury on 12/23/13 who had undergone left carpal tunnel release and release of the left first dorsal compartment on 5/7/14. Following the surgery, the patient is noted to have improvement in her left-sided symptoms but is being treated for right wrist pain. During her post-operative recovery she also complained of left basilar joint pain and signs and symptoms of possible right carpal tunnel syndrome. Conservative management consisted of NSAIDs, ice, bracing, activity modification, and hand therapy. Recommendation was made for electrodiagnostic studies of the right upper extremity due to possible right carpal tunnel syndrome and failure of conservative management. On several occasions, the patient is noted to have made significant but incomplete improvement with therapy. Additional requests for 12 therapy visits had been made. The patient appeared to have had 24 post-operative physical therapy visits approved. Physical therapy note dated 10/20/14 notes visit 27 out of 24 and that a home exercise program was given as no further physical therapy was authorized. Utilization review dated 10/16/14 did not certify 12 sessions of hand therapy that were requested on 10/9/14. Reasoning given was that the patient had already been authorized for 24 physical therapy visits and possibly has already participated in 26 visits. Physical therapy notes do not document any significant functional deficit to support further exceeding treatment guidelines when a self-directed home exercise program should suffice. The requesting surgeon notes on appeal that the patient had recent aggravation of pain into her bilateral hands. Physical therapy was recommended as an adjuvant treatment to further decrease pain and increase function. This is based on Chronic Pain Medical Treatment Guidelines. Further physical therapy was also recommended based on postoperative treatment following left carpal tunnel release and left De Quervain's release as the patient has remaining functional deficits. Finally, based of ODG, 'More visits may be necessary when grip strength is a problem

even if range of motion is improved.' She had regained full range-of-motion but had continued pathology of both hands.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Hand therapy, Qty: 12 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 15-16, 21.

Decision rationale: The patient is a 35 year old female who had undergone left carpal tunnel release and left De Quervain's release on 5/7/14. She is documented to have been approved for 24 therapy visits and had attended 27 visits. She is noted to complain of additional left basilar thumb pain and increasing symptoms on the right side consistent with right carpal tunnel syndrome. The patient has exceeded the post-surgical treatment guidelines for carpal tunnel release and De Quervain's release as noted below. There has been insufficient documentation from the requesting surgeon's follow-up notes of specific functional gains that have been made to warrant further therapy based on post-surgical guidelines. The report from 9/22/14 notes 'no significant change on the left side. The requesting surgeon noted that the patient had aggravation of pain in both hands during her recovery from left sided surgery, as well as pathology of both hands. From Chronic Pain Treatment Guidelines, physical medicine/therapy may be indicated for chronic pain. However, as stated 'Patients are instructed and expected to continue active therapies at home.' A home exercise program had not been adequately documented by the requesting surgeon and only at the last physical therapy visit, was this addressed. In summary, the patient has exceeded post-surgical guidelines following her left carpal tunnel surgery and left De Quervain's release. There was insufficient detail of functional improvement to justify further treatment beyond the guidelines. In addition, based on a chronic pain and/or continued pathology of the bilateral hands, the patient has not been adequately documented to have undergone a home exercise program and thus would not satisfy for physical medicine as well. Thus, continued physical therapy would not be considered medically necessary for this patient. From Post-Surgical Treatment Guidelines with respect to carpal tunnel: Recommended as indicated below. There is 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, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is a relatively simple operation that also should not require extended multiple therapy office visits for recovery. Of course, these statements do not apply to cases of failed surgery and/or misdiagnosis (e.g., CRPS (complex regional pain syndrome) I instead of CTS).

(Feuerstein, 1999) (O'Conner-Cochrane, 2003) (Verhagen-Cochrane, 2004) (APTA, 2006) (Bilic, 2006) Post surgery, a home therapy program is superior to extended splinting. (Cook, 1995) Continued visits should be contingent on documentation of objective improvement, i.e., VAS (visual analog scale) improvement greater than four, and long-term resolution of symptoms. Therapy should include education in a home program, work discussion and suggestions for modifications, lifestyle changes, and setting realistic expectations. Passive modalities, such as heat, iontophoresis, phonophoresis, ultrasound and electrical stimulation, should be minimized in favor of active treatments. Carpal tunnel syndrome (ICD9 354.0): Postsurgical treatment (endoscopic): 3-8 visits over 3-5 weeks* Postsurgical physical medicine treatment period: 3 months Postsurgical treatment (open): 3-8 visits over 3-5 weeks* Postsurgical physical medicine treatment period: 3 months With respect to De Quervain's release: Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04): Postsurgical treatment: 14 visits over 12 weeks* Postsurgical physical medicine treatment period: 6 months Chronic Pain Medical Treatment Guidelines Physical Medicine, page(s) 98-99: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines - Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. Therefore, this request is not medically necessary.