MAXIMUS Federal Services

Case Number:	CM14-0072972		
Date Assigned:	07/16/2014	Date of Injury:	11/15/2011
Decision Date:	09/12/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/20/2014

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 Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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 51-year-old female who reported an injury on 11/15/2011 from repetitive motion at work. The injured worker had a history of bilateral wrist and hand pain, bilateral elbow pain that radiated to the shoulders and neck. The diagnoses included bilateral medical epicondylitis, bilateral lateral epicondylitis, bilateral compressive neuropathy, ulnar nerve distribution. The prior surgeries included a left carpal tunnel release dated 08/08/2013 and a right carpal tunnel release dated 02/13/2014. The prior diagnostics included an electromyogram/nerve conduction study dated 01/20/2014, no results available for review. The past treatments included 8 sessions of physical therapy, electrostimulation, hot/cold packs and home exercises. The medications included oxycodone and a sleeping aid. No VAS provided. The objective findings dated 03/10/2014 of the right wrist revealed a recent scar with no signs of infection. The examination of the right elbow revealed tenderness to palpation to the lateral epicondyle, the left demonstrated tenderness to palpation over the lateral epicondyle, right wrist revealed a well healed scar with no signs of infection. Per the neurologically findings no headache, no loss of consciousness or seizures, and musculoskeletal The Treatment plan included postoperative physical therapy of the right wrist with 3/8 sessions completed, continue all medications as directed, and return for followup. The Request for authorization was submitted on 07/16/2014 with the documentation. The rationale was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Occupational Therapy Visits for the Bilateral Hands, Wrist, and Elbows (05/01/2014 - 06/15/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Carpal Tunnel Syndrome Page(s): 98.

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

Decision rationale: The request for 8 occupational physical therapy visits for the bilateral hands, wrists, elbows (05/01/2014 to 06/15/2014) is non-certified. The California MTUS recommend physical/ Occupational Therapy as indicated below. There is limited evidence demonstrating the effectiveness of physical therapy or occupational therapy for 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. Post-surgery, a home therapy program is superior to extended splinting. Continued visits should be contingent on documentation of objective improvement, example, such as the 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. For Carpal tunnel syndrome 3-8 visits over 3-5 weeks with a postsurgical physical medicine treatment period: 3 months. Per the documentation provided, the last clinical note was for 03/10/2014 and did not provide a VAS. The injured worker had not completed the first 8 sessions of physical therapy. The injured worker was only 7 weeks postop at the third physical therapy visit. Per the guidelines, prolonged therapy is not supported and carpal tunnel syndrome should not result in extended time off work. The documentation was not evidence of any special circumstances to warrant additional therapy. As such, the request for Occupational Therapy is not medically necessary.