Case Number:	CM14-0196125		
Date Assigned:	12/04/2014	**Date of Injury:**	11/10/2012
Decision Date:	01/29/2015	**UR Denial Date:**	11/11/2014
Priority:	Standard	**Application Received:**	11/24/2014

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 Rehab, has a subspecialty in Pain Medicine 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:

This 55 year old female was injured on 11/10/2012 and sustained injury to her right hand after a trip and fall where she used her right hand to break her fall. She had immediate pain and was seen in an emergency room where radiographs revealed dislocation of her little finger. The finger was reset. She had physical therapy. Her pain intensity was 6/10. She experienced constant pain on the palm near the wrist with radiation into three small fingers with loss of right hand grip strength. She also experienced impairment with activities of daily living (ADL) (dressing, housework, driving and sleeping through the night). On physical exam there is tenderness and swelling of the proximal interphalangeal (PIP) joint of the fifth finger of the right hand. There is stiffness of the proximal PIP joint and decreased range of motion due to pain and swelling. Motor sensory exam of the right upper extremity is normal. She exhibits positive Tinel's sign over the carpal tunnel and positive Phalen's test. Radiographs of the right hand and wrist (5/21/14) were normal. Diagnoses include status post right carpal tunnel release with ulnar nerve decompression at the wrist; right trigger thumb; right cubital tunnel syndrome; status post right small PIP dislocation with post traumatic stiffness. The medications were Norco and an anti-inflammatory but documentation is unclear if she continued with these medications. Documentation also indicates that she was evaluated by a urine drug screen to determine the level of prescription medications but there are no results documented. Documentation (5/21/14) indicates failed conservative treatment with positive nerve testing and carpal tunnel release will be recommended. On 7/28/14 right carpal tunnel release and right ulnar nerve decompression at the wrist was done. She was fitted with a right carpal tunnel sleeve. Since the surgery she underwent occupational therapy. By 10/28/14 both Tinel's and Phalen's were negative and there was tenderness and triggering at the A-1 pulley of the right thumb. She underwent a right thumb digital block. Therapy was to focus on range of motion, modalities and strengthening. Her work

restrictions include no heavy, repetitive or forceful use of the right hand. Documentation indicates that the injured worker has not worked since the injury. Her functional capacity is not clearly documented but her symptoms have improved. On 11/5/14 occupational therapy was requested.On 11/11/14 Utilization Review non-certified the request for additional occupational therapy 2X6, right hand, wrist, thumb based on prior certification for 24 post-operative occupational therapy sessions making additional session in excess of the recommendations and documentation to support addition of therapy sessions has not been established. The guidelines referenced were MTUS Chronic Pain Guidelines and ODG.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Occupational Therapy 2 times a week for 6 weeks to the Right Hand, Wrist and Thumb: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99,Postsurgical Treatment Guidelines Page(s): 8-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow/Wrist and Carpal Tunnel Syndrome Chapters, Physical Therapy

Decision rationale: The ACOEM Practice Guidelines, Forearm, Wrist and Hand Complaints Chapter on page 265 recommends physical therapy to include:"Instruction in home exercise. Except in cases of unstable fractures, acute dislocations, instability or hypermobility, patients can be advised to do early pendulum or passive ROM exercises at home. Instruction in proper exercise technique is important, and a few visits to a good physical therapist can serve to educate the patient about an effective exercise program." The Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter, Physical Therapy has more specific recommendation regarding physical therapy for this body region including:"Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT or OT for CTS. The evidence may justify one pre-surgical visit for education and a home management program, or 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 physical therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is an effective operation that also should not require extended multiple physical therapy office visits for recovery. Of course, these statements do not apply to cases of failed surgery and/or misdiagnosis (e.g., CRPS I instead of CTS). (Feuerstein, 1999) (O'Conner-Cochrane, 2003) (Verhagen-Cochrane, 2004) (APTA, 2006) (Bilic, 2006) Post surgery a home physical therapy program is superior to extended splinting. (Cook, 1995) This RCT concluded that there was no benefit in a 2-week course of hand therapy after carpal tunnel release using a short incision, and the cost of supervised therapy for an uncomplicated carpal tunnel release seems unjustified. (Pomerance, 2007) Continued visits should be contingent on documentation of objective improvement, i.e., VAS 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. See also more specific physical therapy modalities.ODG Physical Medicine Guidelines - Allow for fading of treatment frequency, plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.Carpal tunnel syndrome (ICD9 354.0):Medical treatment: 1-3 visits over 3-5 weeksPost-surgical treatment (endoscopic): 3-8 visits over 3-5 weeksPost-surgical treatment (open): 3-8 visits over 3-5 weeks"Further the Official Disability Guidelines Elbow & Upper Arm Chapter state the following:"Amputation of arm, above the elbow Post-surgical treatment: without complications, no prosthesis: 18 visits over 4 monthsPost-Surgical physical medicine treatment period: 6 monthsPost-surgical treatment: without complications, with prosthesis: 30 visits over 6 monthsPost-Surgical physical medicine treatment period: 9 monthsPost-surgical treatment: with complications, no prosthesis: 30 visits over 5 monthsPost-Surgical physical medicine treatment period: 7 monthsPost-surgical treatment: with complications and prosthesis: 40 visits over 8 monthsPost-Surgical physical medicine treatment period: 12 months"In this worker, there is documentation of a prior certification for 24 post-operative occupational therapy sessions. Per guidelines, the new request is in excess of guidelines and is not medically necessary.