

Case Number:	CM15-0181289		
Date Assigned:	09/22/2015	Date of Injury:	05/03/1999
Decision Date:	10/27/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/14/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 female who sustained an industrial injury on 5-3-1999. She reported upper extremity repetitive strain injury. Diagnoses include carpal tunnel syndrome, status post right carpal tunnel release and revision. Treatments to date include physical-occupational therapy. Currently, she complained of increased symptoms in bilateral upper extremities. On 8-13-15, the physical examination documented diffuse tenderness of bilateral forearms, well-healed incisions with tenderness, and positive Tinel's, Phalen's, and Compression tests on the left side. The plan of care included therapy for her flare and splints at night. An initial therapy evaluation was completed on 8-21-15, documented pain level rated at 4 out of 10 VAS with complaints of pain and frozen fingers, greater on the right side than left. Range of motion measurements revealed 20 out of 45 for bilateral wrist flexion and extension, and 15 out of 40 in bilateral ulnar-radial deviation, as well as decreased strengths. The therapy plan of care included non-specified goals including increase range of motion, increase strength, decrease pain, decreased edema, and ergonomic training. The appeal requested authorization of twelve (12) hand therapy sessions twice a week for six weeks for bilateral wrists. The Utilization Review dated 8-28-15, denied the request stating, "The available clinical information does not support that the request is medically reasonable and necessary." per the Official Disability Guidelines and California MTUS Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hand therapy 2 times a week for 6 weeks for the bilateral wrists: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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 Syndrome (Acute & Chronic), physical therapy.

Decision rationale: The claimant sustained a work injury in May 1999 and is being treated for bilateral carpal tunnel syndrome. She had right carpal tunnel release revision surgery in February 2012. In March 2012, a left carpal tunnel release had been approved. When seen, she had decided not to undergo the left-sided surgery. She was having a flare-up of symptoms. Physical examination findings included diffuse forearm tenderness bilaterally with positive left Tinel's, Phalen's, and carpal compression testing. Recommendations included continued use of nighttime splints. Authorization for therapy was requested. There is limited evidence demonstrating the effectiveness of therapy for carpal tunnel syndrome. When managed medically, guidelines recommend up to 1-3 treatment sessions over 3-5 weeks. In this case, the number of visits requested is in excess of that recommended or what might be needed to determine whether continued physical therapy was necessary or likely to be effective. The request is not medically necessary.