

Case Number:	CM15-0202734		
Date Assigned:	10/19/2015	Date of Injury:	12/31/2008
Decision Date:	12/01/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	10/15/2015

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: Montana, Oregon, Idaho
 Certification(s)/Specialty: Orthopedic Surgery

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 46 year old male who sustained an industrial injury December 31, 2008. Past history included status post cervical spinal fusion C5-6, C6-7 with cervical laminotomy, laminectomy and decompression of the C5-6 nerve roots, October 7, 2014 and internal neurolysis of median nerve, decompression of median nerve within carpal tunnel, decompression of ulnar nerve in Guyon canal, median and ulnar nerve block for pain control, tenosynovectomy right side March 2012 and status post carpal tunnel release, right hand July 7, 2015. The injured worker had completed 11 of 12 physical therapy sessions as of June 1, 2015, for complaints of neck and right shoulder pain. According to a primary treating physician's progress report dated September 3, 2015, the injured worker presented as a follow-up visit. (A note from a secondary treating physician September 4, 2015, finds the injured worker complaining of ongoing pain and numbness in the right hand. The physician documented, he has not had physical therapy since the carpal tunnel surgery). Objective findings included; cervical spine tenderness and decreased range of motion; carpal tunnel wound healed and sutures discontinued; decreased sensation C6 right upper extremity. There are two typed notations; x-ray good position of hardware C5-7 and EMG NCV (electromyography-nerve conduction velocity studies) bilateral upper extremity C6-7 radiculopathy, right moderate bilateral carpal tunnel syndrome. Diagnoses are brachial neuritis, not otherwise specified; cervical disc degeneration. At issue, is the request for authorization for physical therapy, 12 sessions, 3 x 4, right hand-wrist. According to utilization review dated September 16, 2015, the request for (12) Physical Therapy Sessions (3 x 4) right wrist-hand is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Physical Therapy sessions, 3 x 4, Right Wrist, Right Hand: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Carpal Tunnel Syndrome.

Decision rationale: According to the CA MTUS ACOEM postsurgical treatment guidelines, page 15, 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. In this case, the requested number of visits exceeds the maximum number in the cited guidelines. Therefore the request is not medically necessary.