Case Number:	CM15-0221688		
Date Assigned:	11/17/2015	Date of Injury:	08/23/2012
Decision Date:	12/24/2015	UR Denial Date:	10/12/2015
Priority:	Standard	Application Received:	11/11/2015

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
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 48 year old male, who sustained an industrial injury on August 23, 2012, incurring upper extremity injuries. He was diagnosed with carpal tunnel syndrome, injury to the ulnar nerve, lateral epicondylitis and a shoulder lesion. Treatment included pain medications, anti-inflammatory drugs, neuropathic medications, acupuncture, more than 12 sessions of physical therapy, transcutaneous electrical stimulation unit, cortisone injections and antidepressants. Electromyography studies revealed bilateral neuropathy at the wrists and ulnar neuropathy at the bilateral elbows. He underwent a left cubital tunnel release, carpal tunnel release and left thumb release in May 2015. He experienced initial improvement with physical therapy but the pain worsened with activity. He noted numbness and tingling, swelling and hypersensitivity of his hands. Currently, the injured worker complained of worsening bilateral upper extremity pain and discomfort. The pain radiated from the fingers up into the arms. He noted difficulty gripping and grasping and difficulty with his activities of daily living. Current diagnoses include those noted above, as well as bilateral medial epicondylitis and CRPS type II verses neuropathic pain in the right hand. The treatment plan that was requested for authorization included six physical therapy sessions for bilateral upper extremities. On October 12, 2015, a request for physical therapy for the upper extremities was denied by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 physical therapy sessions bilateral upper extremities (BLE): Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Forearm, Wrist, & Hand.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) CRPS Treatment.

Decision rationale: The MTUS in the Chronic Pain Medical Treatment Guidelines recommends physical therapy 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. The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. The American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) guidelines state that physical therapy is recommended for education and establishment of a home exercise program. Physical modalities, such as massage, diathermy, cutaneous laser treatment, "cold" laser treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback have no scientifically proven efficacy in treating acute hand, wrist, or forearm symptoms. Limited studies suggest there are satisfying short- to medium-term effects due to ultrasound treatment in patients with mild to moderate idiopathic carpal tunnel syndrome (CTS), but the effect is not curative. Patients' at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. 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. The ODG guidelines for CRPS note that physical modalities include desensitization, isometric exercises, resisted range of motion, and stress loading. If not applied appropriately, PT may temporarily increase symptoms, particularly if too aggressive. Continued steps include continued active ROM, stress loading, scrubbing techniques, isotonic strengthening, general aerobic conditioning, and postural normalization. In this case, the medical records do note that the injured worker has had postoperative physical therapy in the past and has been performed home exercises. The recent treatment notes indicate new diagnoses of bilateral medial epicondylitis and, with significant recurrence of neuropathic pain, a diagnosis of chronic regional pain syndrome

type II verses neuropthic pain has been considered. The primary treating physician has requested physical therapy x6 for the bilateral upper extremities. The MTUS would support up to 24 visits targeting neuropathic pain and chronic regional pain syndrome. The request for 6 physical therapy sessions for the bilateral upper extremities is medically necessary.