

Case Number:	CM15-0052536		
Date Assigned:	03/26/2015	Date of Injury:	12/22/2010
Decision Date:	05/01/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/19/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 52 year old female, who sustained an industrial injury on December 22, 2010. She reported painful and swollen hands. The injured worker was diagnosed as having bilateral carpal tunnel syndrome, bilateral de Quervain's syndrome, and bilateral extensor carpi ulnaris tendinitis. Treatment to date has included EMG/NCS (electromyography/nerve conduction study), wrist splints, physical therapy, home exercise program, acupuncture, work modifications, and non-steroidal anti-inflammatory medication. On February 12, 2015, the injured worker complains of constant numbness and tingling of the bilateral hands and bilateral wrist pain with tenderness to palpation of the bilateral 1st dorsal compartment and bilateral extensor carpi ulnaris (ECU) tendons. Her medications help the pain. The physical exam revealed guarding of hands, stiffness with protective movement, full range of motion, and bilateral ulnar, dorsal and volar wrist tenderness. There was mildly decreased grip strength bilaterally, intact sensation, and ability to finger touch palmar crease and thumb touch metacarpal head bilaterally. The treatment plan includes physical therapy twice a week for three weeks for the bilateral hands and wrists and bilateral wrist braces.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Physical therapy visits: 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.

Decision rationale: According to MTUS guidelines, Physical Medicine is “Recommended 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. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007). There is no documentation of objective findings that support musculoskeletal dysfunction. There is no documentation of the outcome of previous physical therapy sessions. There is no documentation supporting additional physical therapy sessions. Therefore 6 Physical therapy visits is not medically necessary.

1 bilateral wrist brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Splinting, <http://www.odg-twc.com/index.html>.

Decision rationale: According to MTUS and ODG guidelines, splinting recommend splinting of wrist in neutral position at night & day prn, as an option in conservative treatment. Use of daytime wrist splints has positive, but limited evidence. Splinting after surgery has negative evidence. When treating with a splint, there is scientific evidence to support the efficacy of neutral wrist splints in CTS, and it may include full-time splint wear instructions as needed, versus night-only. Carpal tunnel syndrome may be treated initially with a splint and medications before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits). Outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases. Nevertheless, surgery should not

be performed until the diagnosis of CTS is made by history, physical examination and possible electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis, however the benefit from these injections although good is short-lived. Two prospective randomized studies show that there is no beneficial effect from postoperative splinting after carpal tunnel release when compared to a bulky dressing alone. In fact, splinting the wrist beyond 48 hours following CTS release may be largely detrimental, especially compared to a home physical therapy program. (Banta, 1994) (Bury, 1995) (Courts, 1995) (Finsen, 1999) (Walker, 2000) (Gerritsen-JAMA, 2002) (Goodyear-Smith, 2004) (Muller, 2004) (Sevim, 2004) (Werner, 2005) (Premoselli, 2006) (Ucan, 2006) A hand brace significantly improves symptoms after four weeks. There is limited evidence that a nocturnal hand brace improves symptoms, hand function and overall patient-reported change in the short-term (up to four weeks of use). There is limited evidence that night-only wrist splint use is equally effective as full-time wrist splint use in improving short-term symptoms and hand function. There is limited evidence that neutral wrist splinting results in superior short-term overall and nocturnal symptom relief (at two weeks) when compared with wrist splinting in extension. Furthermore, limited evidence suggests that short-term daytime symptom relief is similar for both splint groups. (O'Conner-Cochrane, 2003) It is concluded that steroid injections and wrist splinting may be effective for relief of CTS symptoms but have a long-term effect in only 10 percent of patients. Symptom duration of less than 3 months and absence of sensory impairment at presentation are predictive of a lasting response to conservative treatment. Selected patients (i.e., with no thenar wasting or obvious underlying cause) presenting with mild to moderate carpal tunnel syndrome may receive either a single steroid injection or wear a wrist splint for 3 weeks. This will allow identification of the 10 percent of patients who respond well to conservative therapy and do not need surgery. (Graham, 2004) Statistical evaluation identified five factors which were important in predicting lack of response to wrist splints: (1) age over 50 years, (2) duration over ten months, (3) constant paraesthesiae, (4) stenosing flexor tenosynovitis, and (5) a Phalen's test positive in less than 30 seconds. When none of these factors was present, 66% of patients were cured by medical therapy, 40% of patients with one factor, 17% with two factors, and 7% with three factors, and no patient with four or five factors present was cured by medical management. (Kaplan, 1990) Data suggest that splinting is most effective if applied within three months of symptom onset. (Kruger, 1991) This systematic review found that the usefulness of splinting as initial treatment for improving CTS symptoms is still supported by recent literature, but these effects are temporary. (Bernardino, 2011). Therefore, wrist splinting is not recommended for chronic wrist pain or remotely after carpal tunnel release. Therefore, the request for bilateral wrist brace is not medically necessary.