

Case Number:	CM15-0016813		
Date Assigned:	02/05/2015	Date of Injury:	07/25/2014
Decision Date:	03/27/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/29/2015

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: California
Certification(s)/Specialty: Internal 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 37 year old female, who sustained an industrial injury on July 25, 2014. The diagnoses have included carpal tunnel syndrome. Treatment to date has included physical therapy, acupuncture therapy, medications and diagnostic studies to include EMG/Nerve Conduction Studies MRI and CT scans. The injured worker complained of constant right wrist pain described as dull, splitting, numbing, tingling and cramping in nature. The pain was associated with weakness and locking in the fingers. The injured worker has been certified to have right carpal tunnel release surgery. On December 30, 2014, Utilization Review modified a request for post-operative physical therapy to the right wrist and post-operative cold therapy unit, noting that the request for twelve sessions of physical therapy exceeded the guidelines recommendation and was modified to eight sessions of physical therapy; and the guidelines allow for a seven-day rental of a cold therapy unit rather than cold therapy unit purchase. The California Medical Treatment Utilization Schedule and Official Disability Guidelines were cited. On January 29, 2015, the injured worker submitted an application for IMR for review of post-operative physical therapy to the right wrist and post-operative cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Postoperative physical therapy twice a week for four weeks for the right wrist: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses post-operative physical therapy (PT) physical medicine. The Postsurgical Treatment Guidelines indicate that for carpal tunnel syndrome, 3-8 visits of postsurgical physical therapy are recommended. Medical records document the diagnosis of right carpal tunnel syndrome. The utilization review determination letter dated 12-30-2014 documented that right carpal tunnel release surgery was certified. Twelve physical therapy visits were requested. The request 12 physical therapy visits exceeds MTUS Postsurgical Treatment Guidelines, and is not supported. Therefore, the request for post-operative PT physical therapy twice a week for four weeks (12) is not medically necessary.

Postoperative cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome (Acute & Chronic) Continuous cold therapy (CCT)

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses passive modalities. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints Table 11-7 Summary of Recommendations for Evaluating and Managing Forearm, Wrist, and Hand Complaints (Page 271) indicates that passive modalities are not recommended. Official Disability Guidelines (ODG) Carpal Tunnel Syndrome (Acute & Chronic) indicates that continuous cold therapy (CCT) is an option only in the postoperative setting, with regular assessment to avoid frostbite. Postoperative use generally should be no more than 7 days, including home use. Complications related to cryotherapy, including frostbite, are can be devastating. Medical records document the diagnosis of right carpal tunnel syndrome. The utilization review determination letter dated 12-30-2014 documented that right carpal tunnel release surgery was certified. A post-operative cold therapy unit was requested. ODG guidelines indicate that postoperative use of continuous cold therapy (CCT) generally should be no more than 7 days. The request indicates the purchase of a cold therapy unit, with indefinite use, which is not supported by ODG guidelines. Therefore, the request for a post-operative cold therapy unit is not medically necessary.