Matriarch
CONSULTING SERVICES

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REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who injured on XXXX when XXXX. The claimant was diagnosed with traumatic brain injury and carpal tunnel syndrome. XXXX fractured 4 ribs and sustained a laceration to XXXX face. The claimant was admitted to the hospital for 4 days. CT imaging demonstrated subcortical white matter disease and cortical atrophy in the brain. No neurosurgery was performed. Prior treatment has included physical therapy and chiropractic treatment. Twelve sessions of physical therapy were previously certified in XXXX. An occupational evaluation dated XXXX noted that the claimant had stiffness with pain and lack of coordination. The claimant had difficulty with fine motor tests at home, causing XXXX to become frustrated and to avoid those activities. Additional therapy sessions were recommended. Per XXXX neurological exam dated XXXX, the claimant had a MRI on XXXX that showed moderate ischemic changes. EMG done on XXXX showed peripheral neuropathy, severe carpal tunnel syndrome on the right, mild bilateral ulnar palsy, left greater than right C5 radiculopathy, moderate bilateral C6 radiculopathy, moderate to severe right C7 radiculopathy, moderate bilateral L4 radiculopathy, moderate bilateral L5 radiculopathy. BMI is 31.8. Neuro exam showed pertinent for normal coordination, motor normal, tone normal, fine finger movement normal, ADB 1 (typo), DTRs 2+ and equal. Sensory showed pin split 4th median finger on the right, some sensory findings consistent with known pattern seen with peripheral neuropathy. Gait and station were normal. No pathological reflexes. The request is for occupational therapy twice a week for 8 weeks.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the records submitted, the request for Occupational Therapy twice a week for 8 weeks is not recommended and not medically necessary. The claimant has been previously treated with occupational therapy but it is not clear how many total occupational therapy visits the claimant has completed to date. The records submitted showed no documentation of significant deficits that warrant additional occupational therapy sessions. To determine whether additional occupational therapy was indicated currently, it would be necessary that the office notes document history, physical examination, current functional abilities, and specific goals of proposed additional occupational therapy. The most recent exam by a treating physician, XXXX dated XXXX documented the accepted diagnoses include traumatic brain injury and carpal tunnel syndrome. The claimant's exam showed good fine finger movements, normal strength/motor exam, normal deep tendon reflexes, and normal findings except for those consistent with pattern seen with carpal tunnel syndrome on the right and peripheral neuropathy. There is no indication that the claimant had pain with examination. Regarding occupational therapy for the traumatic brain injury, without current neurological findings such as ataxia, reduced fine finger movements, motor weakness or

sensory loss other than that attributable to known diagnoses of carpal tunnel syndrome or peripheral neuropathy, there is no information to support the request for occupational therapy. Also, according to the Official Disability Guidelines (ODG), there is limited evidence demonstrating the effectiveness of physical therapy or occupational therapy for carpal tunnel syndrome. The evidence may justify one pre-surgical visit for education and a home management program, or 3 to 5 visits over 4 weeks after surgery. Furthermore, ODG indicates carpal tunnel release surgery is an effective operation that also should not require extended multiple physical therapy office visits for recovery. Thus, the medical necessity has not been established for the requested occupational therapy twice a week for 8 weeks.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
Pain (Chronic) - (Updated 05/09/18)
Occupational therapy (OT)
See Physical therapy.
Physical medicine treatment
ODG Physical Therapy Guidelines –
Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.
Myalgia and myositis, unspecified:
9-10 visits over 8 weeks
Neuralgia, neuritis, and radiculitis, unspecified:
8-10 visits over 4 weeks
Reflex sympathetic dystrophy (CRPS):
26 visits over 16 weeks
Arthritis:
9 visits over 8 weeks
Post-injection treatment: 1-2 visits over 1 week
Post-surgical treatment (see also body-part chapters): 18 visits over 12 weeks

Patients should be formally assessed after a "six-visit clinical trial" to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy.
Physical medicine encompasses interventions that are within the scope of various practitioners (including Physical Therapy, Occupational Therapy, Chiropractic, and MD/DO). Passive therapies (those treatment modalities that do not require energy expenditure on the part of the patient) are not indicated for addressing chronic pain in most instances; refer to the specific modality within ODG (e.g., massage, ultrasound). 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. Refer to the specific intervention within these guidelines (e.g., exercise). 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) As far as medical necessity considerations for exercise equipment, see the Knee Chapter, Durable medical equipment (DME), & the Low Back Chapter, Exercise. 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)

Carpal Tunnel Syndrome (Acute & Chronic) - (updated 05/25/18)
Physical medicine treatment
Recommended as indicated below.
ODG Physical Medicine Guidelines –
Allow for fading of treatment frequency, plus active self-directed home PT. Also, see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.
Carpal tunnel syndrome:
Medical treatment: 1-3 visits over 3-5 weeks
Post-surgical treatment (open or endoscopic): Not recommended, but 3-8 visits over 3-5 weeks for unusual levels of pain or stiffness
There is only limited evidence demonstrating any effectiveness of physical or occupational therapy for carpal tunnel syndrome (CTS), but there may be justification for one pre-surgical visit for education and a home management program, but rarely following surgery. CTS should not result in extended time off work while attending multiple therapy visits, when other options (including surgery) can result in faster return to work. Carpal tunnel release (CTR) is an effective operation that also does not require extended or multiple therapy visits during recovery, although failed surgery and/or misdiagnosis (e.g., CRPS) may benefit. (Feuerstein, 1999) (O'Conner-Cochrane, 2003) (Verhagen-Cochrane, 2004) (APTA, 2006) (Bilic, 2006)
Post-surgery a home physical therapy program is superior to extended splinting. (Cook, 1995) An RCT concluded that there was no benefit for a 2-week course of hand therapy following CTR using a short incision, with costs of supervised therapy for uncomplicated CTR being unjustified. (Pomerance, 2007) Limited therapy should include home program education, 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.
A Cochrane systematic review of rehabilitation following CTR involving 22 trials and 1521 patients concluded that there was limited low-quality evidence to support any therapy or specific interventions following surgery. (Peters, 2016)