

<b>Case Number:</b>	CM15-0105250		
<b>Date Assigned:</b>	06/09/2015	<b>Date of Injury:</b>	03/23/2009
<b>Decision Date:</b>	07/10/2015	<b>UR Denial Date:</b>	05/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 56 year old female, who sustained an industrial injury on March 23, 2009. Treatment to date has included hand therapy, medications, and injections. Currently, the injured worker complains of continued left upper extremity pain. She describes the pain as aching and a lancinating sensation. The pain is exacerbated with increased activity and lifting objects and is relieved with medications and injection therapy. On physical examination, the injured worker has pain, swelling and allodynia across the left hand. When she presses on her hand she reports tingling in the biceps and she has lost grip strength. Her physical therapy is limited due to pain. The diagnoses associated with the request include reflex sympathetic dystrophy of the upper limb, chronic pain syndrome, and neuralgia, neuritis and radiculitis. The treatment plan includes continued physical therapy and stellate blocks, and medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 1XWk x 12 Wks for the left hand: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Physical Medicine Treatment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant has a remote history of a work injury occurring in March 2009 and continues to be treated for left upper extremity pain including a diagnosis of CRPS. Physical therapy had been relatively ineffective in the past due to pain. When seen, findings were consistent with her diagnosis of CRPS. Prior treatments had included three stellate ganglion blocks with improved therapy tolerance. Being requested is authorization for additional blocks as well as 12 physical therapy treatment sessions. The claimant is being treated for chronic pain. There is no new injury. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended. Additionally, without coordination of adequate pain relief the requested therapy is not likely to be well tolerated or effective. The request is not medically necessary.