

<b>Case Number:</b>	CM15-0131325		
<b>Date Assigned:</b>	07/17/2015	<b>Date of Injury:</b>	01/01/2013
<b>Decision Date:</b>	08/17/2015	<b>UR Denial Date:</b>	07/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2015

### 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: 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 41 year old female, who sustained an industrial injury on 1/01/2013. The details of the initial injury were not documented in the medical records submitted for this review. Diagnoses include status post right carpal tunnel release and cubital tunnel release on 8/19/13 and status post right ulnar nerve transposition on 1/29/14, and status post Open Reduction Internal Fracture (ORIF) of the right wrist. Treatments to date include medication therapy, H-wave stimulator treatments, physical therapy, and a series of Stellate Ganglion Blocks. Currently, she complained of ongoing pain rated 6/10 VAS. On 6/25/15, the physical examination documented discrepancy in temperature in right upper extremity and allodynia. There was decreased grip strength and decreased sensation in the ring and little finger. The treating diagnoses included Reflex Sympathetic Dystrophy (CRPS) of right upper extremity and history of Guillain Barre Syndrome. The plan of care included physical therapy twice a week for four weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the right upper extremity, twice weekly, quantity of eight:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), CRPS, sympathetic blocks (therapeutic).

**Decision rationale:** Patient is status post a series of Stellate Ganglion Blocks of the right wrist. The Official Disability Guidelines stipulate that there should be evidence that physical or occupational therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase. The age of the patient's claim does meet the requirement of the early phase of treatment. I am reversing the previous utilization review decision. Physical therapy for the right upper extremity, twice weekly, quantity of eight is medically necessary.