

<b>Case Number:</b>	CM15-0180232		
<b>Date Assigned:</b>	09/22/2015	<b>Date of Injury:</b>	07/04/2015
<b>Decision Date:</b>	10/28/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/14/2015

### 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 45 year old male who sustained an industrial motor vehicle accident injury on 07/04/2015 with approximately 4 minute loss of consciousness. Multiple diagnostic testing revealed 8 fractures of his back. No surgical intervention was required. The injured worker was diagnosed with closed head trauma, headaches, cervical, thoracic and lumbar spine sprain and strain with history of fractured vertebrae, bilateral shoulder, bilateral knee and bilateral ankle sprain and strain, testicular pain, ribcage pain, abdominal pain, anxiety, stress and depression. According to the treating physician's progress report on July 28, 2015, the injured worker continues to experience frequent headaches associated with dizziness, neck pain radiating into the bilateral upper extremities and increased with movement, bilateral shoulder and arm pain, left greater than right, upper, middle and low back pain with pain radiating to the bilateral lower extremities, bilateral knee and ankle pain, abdominal pain, testicular pain, anxiety, depression, insomnia and nightmares. The injured worker rated his pain from 7-9 out of 10 on the pain scale with activities. The injured worker ambulates with an antalgic gait, uses a walker and wears a lumbar spine, cervical spine and bilateral knee braces. The cervical spine examination demonstrated tenderness over the bilateral paraspinal muscles and upper trapezii and midline tenderness at C2 through T1 with decreased and painful range of motion. Tenderness and spasm were noted over the bilateral thoracic paraspinal muscles with pain out of proportion to the physical findings. The lumbar spine demonstrated tenderness and spasm over the bilateral lumbar paraspinal muscles and quadratus lumborum with positive midline tenderness at L1 through S1. The injured worker was unable to do range of motion. There was

diminished sensation to light touch and pinprick over the paravertebral muscles. The shoulder and upper arm examination demonstrated tenderness and spasm over the bilateral pectoralis, bilateral upper trapezius, latissimus dorsi and rotator cuff with painful and decreased range of motion in all planes. Examination of the knees revealed bilateral diffuse tenderness with decreased and painful range of motion and unable to squat. The calves and ankles were tender with full but painful range of motion. Toes had full range of motion without pain. Prior treatments included diagnostic testing, initial hospitalization, hard back brace, knee braces bilaterally, walker and medications. Current medications were listed as Ibuprofen, Diazepam and Docusate. Treatment plan consists of Cyclobenzaprine, Tramadol, Hydrocodone, and Tylenol #3, Omeprazole, topical analgesics creams, continuing with stool softener, physical therapy rendered at home, neurology consultation, internal medicine consultation and the current request for authorization for an Autonomic Nervous System Evaluation. On 08-19-2015 the Utilization Review determined the request for Autonomic Nervous System Evaluation was not medically necessary or justified based on the Medical Treatment Utilization Schedule (MTUS) guideline which recommends autonomic nervous system evaluation with a diagnosis of complex regional pain syndrome.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Autonomic Nervous System Evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter/Autonomic Nervous System Function Testing Section.

**Decision rationale:** Per the ODG, autonomic nervous system evaluation is not generally recommended as a diagnostic test for CRPS. The ODG recommends assessment of clinical findings as the most useful method of establishing the diagnosis. Specific procedures are not generally recommended, except as indicated below. A gold standard for diagnosis of CRPS has not been established and no test has been proven to diagnose this condition. Assessment of clinical findings is currently suggested as the most useful method of establishing the diagnosis. Recommendations for an adequate CRPS evaluation include the following: (1) There should be evidence that the Budapest (Hardin) criteria have been evaluated for and fulfilled. (2) There should be evidence that all other diagnoses have been ruled out. A diagnosis of CRPS should not be accepted without a documented and complete differential diagnostic process completed as a part of the record. (3) If a sympathetic block is utilized for diagnosis, there should be evidence that this block fulfills criteria for success including that skin temperature after the block shows sustained increase (1.5C and/or an increase in temperature to > 34C) without evidence of thermal or tactile sensory block. Evidence of a Horner's response to upper extremity blocks should be documented. The use of sedation with the block can influence results, and this should be noted. In this case, there is little evidence to suggest that the injured worker suffers from CRPS and the use of an autonomic nervous system evaluation is not recommended by the guidelines. The request for autonomic nervous system evaluation is determined to not be medically necessary.