

<b>Case Number:</b>	CM15-0199977		
<b>Date Assigned:</b>	10/15/2015	<b>Date of Injury:</b>	03/18/2013
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	10/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/12/2015

### 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: New York  
 Certification(s)/Specialty: Pediatrics, 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 32 year old male, who sustained an industrial injury on 3-18-13. The injured worker is diagnosed with upper limb RSD (reflex sympathetic dystrophy syndrome), elbow pain and hand pain. His work status is modified duty; however, if the employer cannot accommodate then he will be considered temporarily totally disabled. Notes dated 9-1-15 and 9-23-15 reveals the injured worker presented with complaints of left elbow pain, skin temperature changes, "allodynia and dysesthias" in his hand. A physical examination dated 9-23-15 revealed right elbow with normal range of motion, right hand was cool to the touch and red in color. Treatment to date has included CBT (cognitive behavioral therapy), medications reduce his pain from 9 out of 10 to 6 out of 10 per note dated 9-23-15, ulnar nerve surgery (2014), functional restoration program and physical therapy. A request for authorization dated 9-28-15 for physical therapy for the right upper extremity (12 sessions), cervical spine MRI for spinal cord stimulator trial, right elbow MRI and referral to PhD for consultation for spinal cord stimulator or intrathecal pump evaluation is denied, per Utilization Review letter dated 10-6-15.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy, right upper extremity, 12 sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow - Physical Therapy.

**Decision rationale:** Per ODG guidelines, general therapy is recommended for up to 3 visits contingent on objective improvement documented (ie. VAS improvement of greater than 4). Further trial visits with fading frequency up to 6 contingent on further objectification of long-term resolution of symptoms, plus active self-directed home PT. The request exceeds the guideline recommendations. The request is not medically necessary and appropriate.

**MRI (magnetic resonance imaging), Cervical spine, for SCS (spinal cord stimulator) trial, Qty 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck - MRI.

**Decision rationale:** Per ACOEM guidelines criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. The documentation shows that the IW is neurologically intact and has not yet been determined to be a surgical candidate. Per ODG guidelines, repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The request is not medically necessary.

**MRI (magnetic resonance imaging), right elbow, Qty 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Elbow Complaints 2007.

**MAXIMUS guideline:** Decision based on MTUS Elbow Complaints 2007, Section(s): Chronic Pain Considerations.

**Decision rationale:** According to ACOEM, for most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. In general, an imaging study may be an appropriate consideration for a patient whose limitations due to consistent symptoms have persisted for 1 month or more, as in the following cases and when surgery is being considered for a specific anatomic defect or to further evaluate potentially serious pathology, such as a possible tumor, when the clinical examination suggests the diagnosis. According to the documentation, the IW had already had surgery on the arm and there was no concern for serious pathology. This request is not medically necessary and appropriate.

**Referral to PhD for consultation for Spinal Cord Stimulator or Intraethical Pump evaluation, Qty 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Implantable drug-delivery systems (IDDSs), Intrathecal drug delivery systems, medications, Psychological evaluations, Spinal cord stimulators (SCS).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck - Spinal cord stimulation (SCS), Pain -.

**Decision rationale:** Per ODG guidelines, a spinal cord stimulator is not recommended except as a last resort for two conditions, selected patients meeting detailed criteria with either Complex Regional Pain Syndrome (CRPS) Type I, or with Failed Back Surgery Syndrome (FBSS). Not recommended for any condition specific to the cervical spine. Per ODG guidelines, indications for implantable drug-delivery systems are for the treatment of primary liver cancer, metastatic colorectal cancer where metastases are limited to the liver, head/neck cancers and severe, refractory spasticity of cerebral or spinal cord origin in patients who are unresponsive to or cannot tolerate oral baclofen therapy. The documentation notes that the IW does not meet the criteria for SCS as his psychological evaluation did not indicate realistic expectations and was CPRS Type 2. The request is not medically necessary and appropriate.