Axiom Resolve

IME EXAMINATION REQUEST PACKET

Denise Harper Right Shoulder & CRPS Type I

CLAIM NO.	WC-2025-02411
DATE OF INJURY	March 12, 2024
EMPLOYER	Southeastern Packaging Solutions
JURISDICTION	Georgia
REPORT DATE	March 3, 2026

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IME Examination Request Packet · Claim WC-2025-02411 · Denise Harper · DOI 03/12/2024 · Report Date 03/03/2026

Key Findings — Contested Medical Issues Requiring IME Resolution

CRPS Type I severity & causation. Carrier IME (Dr. Pierce, 11/2025) disputed severity of Complex Regional Pain Syndrome and limited objective evidence, while treating providers assert work-related etiology and ongoing disability. Spinal cord stimulator trial showed 70% pain reduction, yet permanent implantation authorization remains denied pending utilization review.

MMI status & timing. Carrier IME designated MMI as of November 18, 2025; treating providers dispute this finding and recommend continued active pain management interventions including spinal cord stimulator implantation. Current status remains contested with claim actively litigated.

Reasonableness & necessity of proposed spinal cord stimulator. Temporary trial (January 2026) demonstrated significant functional improvement (70% pain reduction, improved sleep). Carrier denies permanent implantation as premature; treating providers recommend authorization. Medical necessity and appropriateness of permanent device requires independent clarification.

Work capacity & permanent restrictions. Functional capacity evaluation (July 2025) documented severe functional limitations (10 lbs occasional lifting maximum, no overhead reaching, impaired dexterity). Carrier IME opined light-duty capacity exists; FCE findings and treating providers indicate permanent total disability for pre-injury position. Work capacity consensus is required.

Permanent impairment rating dispute. Carrier IME assigned 22% WPI based on MMI declaration; treating providers have not formally stipulated to this rating pending resolution of CRPS severity and ongoing treatment needs. AMA Guides application to this complex case requires independent medical assessment.

Section 1 — Claim Identification

FIELD	VALUE
Claimant	Denise Harper
Date of Birth	November 18, 1976 (Age 49)
Date of Injury	March 12, 2024 (23 months prior to this request)
Employer	Southeastern Packaging Solutions
Job Classification	Industrial Maintenance Technician
State of Jurisdiction	Georgia
Claim Number	WC-2025-02411
Policy Number	SRC-GA-2024-88271
Referring Adjuster	Melissa Grant, Claims Examiner — Summit Ridge Casualty Insurance, Atlanta Catastrophic Claims Unit, ext. 2874
Claimant's Attorney	Lauren Mitchell, Esq. — Mitchell & Avery Workers' Compensation Law, Atlanta, Georgia
IME Physician / Company	To be designated by adjuster (see Action Plan)

Section 2 — Mechanism of Injury

Date of injury: March 12, 2024.

Factual mechanism. Claimant Denise Harper, age 49, was employed as an Industrial Maintenance Technician at Southeastern Packaging Solutions. On March 12, 2024, while performing overhead conveyor equipment repairs, claimant fell approximately 8 feet from an elevated maintenance platform. During the fall, claimant struck a steel guardrail with the right shoulder and arm before impacting a concrete floor. The incident was witnessed by two co-workers and documented by the facility safety supervisor.

Immediate clinical presentation.

- Severe right shoulder pain reported at time of impact
- Inability to raise right arm immediately post-injury
- Transported via ambulance to emergency department

Initial diagnostic findings (March 2024).

- Plain radiographs of right shoulder: negative for fracture
- Significant soft tissue swelling documented
- Orthopedic referral initiated due to persistent weakness and limited range of motion

Body parts involved: right shoulder, right upper extremity (dominant extremity).

Note on mechanism-diagnosis consistency. The mechanism of injury (8-foot fall with direct impact to shoulder and guardrail contact) is consistent with severe soft tissue trauma. Subsequent MRI documentation of full-thickness rotator cuff tear with significant retraction, SLAP lesion, and infraspinatus involvement aligns with the impact mechanism described. No documented inconsistencies between the injury mechanism and the initial orthopedic diagnoses have been identified in the medical record.

Section 3 — Complete Medical Chronology

March 2024 — Date of Injury & Initial Treatment

March 12, 2024. Fall from 8-foot elevated maintenance platform; direct right shoulder impact against steel guardrail and concrete floor. Witnessed incident. Immediate severe pain and functional loss reported.

March 12–18, 2024 — emergency department evaluation. Ambulance transport to emergency department. Plain radiographs right shoulder negative for fracture; significant soft tissue swelling noted. Orthopedic referral initiated. Restricted duty status issued; employer documented as unable to accommodate restrictions.

April 2024 — MRI Right Shoulder

April 2, 2024. Magnetic resonance imaging revealed:

- Full-thickness supraspinatus tendon tear with 3.2 cm retraction
- Partial infraspinatus tear

- SLAP (Superior Labrum Anterior to Posterior) lesion involving superior labrum
- Biceps tendinosis
- Moderate acromioclavicular (AC) joint arthropathy

This imaging defined the structural pathology driving subsequent surgical decision-making.

April–July 2024 — Conservative Care Phase (~4 months)

Claimant underwent conservative (non-surgical) management:

- Physical therapy: 30 visits completed
- Subacromial corticosteroid injection: single injection documented
- Prescription anti-inflammatory medication regimen
- Home exercise program with documented patient compliance
- Pain management consultation initiated

Clinical outcome. Despite 4 months of conservative intervention, claimant reported continued severe pain, loss of grip strength, sleep disturbance, inability to perform overhead activities, and functional plateau / lack of meaningful improvement.

August 2024 — Orthopedic Surgical Consultation

August 14, 2024. Provider: Dr. Benjamin Ortiz, MD, Georgia Advanced Orthopedics.

Clinical assessment. Failed conservative care after 4-month trial; persistent functional deficits despite physical therapy and injections; objective structural pathology (full-thickness rotator cuff tear with retraction) confirmed on MRI.

Surgical recommendation. Arthroscopic rotator cuff repair with biceps tenodesis. Rationale: failed conservative care with persistent objective pathology.

September 2024 — Rotator Cuff Repair Surgery

September 9, 2024. Surgeon: Dr. Benjamin Ortiz, MD. Procedures performed:

1. Arthroscopic rotator cuff repair (supraspinatus / infraspinatus)
2. Biceps tenodesis
3. Subacromial decompression
4. Labral debridement (addressing SLAP lesion)

Post-operative course. Recovery complicated by severe pain response. Progressive stiffness documented in immediate post-operative period. Standard post-operative restrictions and rehabilitation initiated.

October 2024 – February 2025 — Post-Surgical Complication Phase (5 months)

Clinical presentation. Progressive development of atypical pain and autonomic features:

- Hypersensitivity (allodynia) of right upper extremity
- Temperature changes
- Swelling
- Burning pain quality
- Pain disproportionate to objective findings

Clinical assessments. Pain management specialist consulted; CRPS suspected based on clinical presentation. Diagnostic imaging: bone scan findings supportive of CRPS Type I diagnosis.

March 2025 — CRPS Type I Diagnosis Confirmed

Duration from injury to CRPS diagnosis: 12 months. Formal diagnostic confirmation based on neurology evaluation, pain management specialist evaluation, clinical history consistent with CRPS diagnostic criteria, and bone scan imaging findings.

Clinical diagnosis: Complex Regional Pain Syndrome Type I, right dominant upper extremity.

Medications initiated. Stellate ganglion block treatment series began. Neuropathic pain medication regimen initiated.

April–August 2025 — Functional Capacity Evaluation

Evaluation date: July 2025. **Duration from injury to FCE: 16 months.**

FCE findings.

- Overhead reaching: no sustained capacity
- Lifting capacity: maximum occasional lifting 10 lbs
- Hand function: marked reduction in right-hand dexterity
- Repetitive activities: unable to perform repetitive gripping or tool usage
- Behavioral observations: pain behaviors and guarding throughout evaluation
- Work capacity conclusion: unable to return to pre-injury maintenance position

Employer confirmation. Southeastern Packaging Solutions confirmed permanent maintenance position unavailable within the claimant's documented restrictions.

September 2025 — Psychological Evaluation

Duration from injury to psychological assessment: 18 months.

Diagnosis: Major depressive disorder secondary to chronic pain condition, occupational disability, and 18-month duration of illness with functional impairment.

Treatment recommendation. Behavioral health treatment added to active claim management.

November 2025 — Carrier IME Examination

November 18, 2025. Duration from injury to IME: 20 months.

IME physician: Randall Pierce, MD, Board Certified Orthopedic Surgery.

IME opinions rendered.

OPINION	STATUS
Work injury materially caused right shoulder pathology requiring surgery	**Causation — Supported**
Rotator cuff repair procedure was reasonable and necessary	**Treatment — Supported**
Objective evidence supporting severe CRPS remains limited	**CRPS Severity — Disputed**
Claimant has reached MMI as of November 18, 2025	**MMI Status — Contested**
Light-duty employment capacity exists with restrictions	**Work Capacity — Contested**
Permanent spinal cord stimulator implantation is premature	**Proposed Treatment — Denied**
Whole person impairment estimated at 22% WPI	**Permanency — Contested**

Disputed findings. The carrier IME opinion regarding CRPS severity, MMI status, work capacity, and spinal cord stimulator appropriateness directly conflicts with ongoing treating provider recommendations and claimant functional presentation.

January 2026 — Spinal Cord Stimulator Trial

Duration from injury to trial: 22 months.

Trial type. Temporary cervical spinal cord stimulator trial (percutaneous lead placement).

Trial outcome.

- Pain reduction: approximately 70%
- Sleep tolerance: improved
- Functional mobility: improved (based on trial response)

Clinical significance. Substantial positive response to neuromodulation therapy documented. Treating providers recommended progression to permanent implantable device.

Carrier response. Permanent spinal cord stimulator implantation denied pending utilization review appeal process.

March 3, 2026 — Current Status (Report Date)

Claim status: Open and actively litigated. **Time since injury:** 23 months.

Current MMI status. Carrier IME designated MMI November 18, 2025; treating providers dispute MMI designation; claim remains open with ongoing active treatment.

Current work status. Off work, receiving temporary total disability (TTD) benefits.

Current medical management. Continued pain management; behavioral health treatment ongoing; awaiting determination on permanent spinal cord stimulator authorization.

Legal status. Represented by attorney Lauren Mitchell, Esq.; settlement discussions ongoing; litigation anticipated absent full settlement resolution.

Section 4 — Contested Issues

Contested Issue #1 — CRPS Type I: Severity, Causation & Ongoing Disability

Issue statement. Whether the claimant's Complex Regional Pain Syndrome Type I, diagnosed 12 months post-injury (March 2025), represents a materially disabling work-related sequela of the shoulder injury requiring ongoing aggressive pain management intervention, or whether CRPS is a self-limited complication with limited objective evidence that does not justify continued intensive treatment and lost work status.

HISTORY OF ISSUE

The claimant underwent successful surgical repair of a well-documented, work-related full-thickness rotator cuff tear on September 9, 2024 (6 months post-injury). Surgery included arthroscopic repair, biceps tenodesis, subacromial decompression, and labral debridement.

Post-operative recovery proceeded with expected pain and stiffness initially. However, beginning in October 2024, the claimant developed atypical pain features including hypersensitivity, temperature changes, swelling, and burning pain affecting the right upper extremity.

By March 2025 (12 months post-injury, 6 months post-surgery), neurology and pain management specialists formally diagnosed Complex Regional Pain Syndrome Type I based on clinical presentation and bone scan findings.

From April to August 2025 (months 13–17 post-injury), a functional capacity evaluation documented severe functional limitations: inability to sustain overhead reaching, maximum occasional lifting of 10 lbs only, marked dexterity loss, and inability to perform repetitive gripping / tool usage.

CARRIER / INSURER POSITION

As expressed in the November 18, 2025 IME report by Dr. Randall Pierce, MD:

> *"Objective evidence supporting severe CRPS remains limited."*

Implication: clinical findings may be disproportionate to objective pathology; CRPS diagnosis may be overstated. By designation of MMI, the carrier position implicitly holds that CRPS has stabilized and does not justify continued intensive intervention. The carrier's denial of permanent spinal cord stimulator authorization pending utilization review reflects skepticism regarding medical necessity and appropriateness of this intervention for CRPS in this case.

TREATING PROVIDERS' POSITION

- CRPS Type I diagnosis is confirmed and appropriate
- CRPS has not resolved or plateaued despite 5+ months of medical management
- Functional incapacity is directly attributable to CRPS, not to the rotator cuff repair itself
- Spinal cord stimulator trial (January 2026) demonstrated 70% pain reduction and improved sleep, supporting progression to permanent implantation
- Continued intensive pain management and neuromodulation therapy are medically necessary and appropriate
- MMI designation is premature and unsupported by functional recovery data

WHY INDEPENDENT MEDICAL OPINION IS REQUIRED

The parties are fundamentally divided on whether objective clinical evidence supports the severity of CRPS symptoms reported by the claimant; whether CRPS is a natural, expected post-operative complication that will resolve with time, or a chronic, disabling condition requiring ongoing aggressive intervention; whether the temporary spinal cord stimulator trial's positive outcome (70% pain reduction) represents sufficient evidence to justify permanent implantation; and whether MMI status is appropriate given ongoing CRPS symptoms and functional limitations.

Contested Issue #2 — Maximum Medical Improvement (MMI) Status & Timing

Issue statement. Whether the claimant has reached maximum medical improvement (MMI) as of November 18, 2025 (20 months post-injury, 14 months post-surgery), or whether active medical treatment with potential for ongoing functional recovery justifies keeping the claim open and maintaining temporary total disability status pending completion of proposed spinal cord stimulator implantation and rehabilitation.

HISTORY OF ISSUE

The claimant underwent rotator cuff repair surgery on September 9, 2024 (6 months post-injury). Standard post-operative rehabilitation and pain management commenced.

As of July 2025 (16 months post-injury, 10 months post-surgery), a functional capacity evaluation documented severe functional limitations without meaningful improvement in overhead function or dexterity.

Between October 2024 and March 2025, CRPS Type I was diagnosed and formally confirmed. Treatment escalation included stellate ganglion block series and neuropathic pain medications.

In November 2025 (20 months post-injury, 14 months post-surgery), the carrier IME physician (Dr. Randall Pierce, MD) designated MMI effective immediately based on the examination and stated opinion that "light-duty employment capacity exists with restrictions."

In January 2026 (22 months post-injury), a temporary spinal cord stimulator trial was performed, documenting 70% pain reduction and improved sleep tolerance. Treating providers recommended progression to permanent implantation.

CARRIER / INSURER POSITION

As stated in the November 18, 2025 IME report: claimant has reached MMI as of November 18, 2025. Rationale: light-duty employment capacity exists; further functional recovery is not anticipated. Implication: any additional medical treatment represents maintenance care or elective intervention, not active rehabilitation toward recovery. Permanent spinal cord stimulator is "premature" — suggesting that MMI status precludes authorization of new interventional procedures.

TREATING PROVIDERS' POSITION

- MMI designation is premature and unsupported by clinical evidence
- Claimant is actively pursuing and responding to new interventional treatment (spinal cord stimulator trial with 70% pain reduction)
- The substantial improvement demonstrated in the January 2026 temporary spinal cord stimulator trial indicates capacity for further functional recovery with permanent device implantation
- Rehabilitation potential remains open pending completion of spinal cord stimulator implantation and post-implantation rehabilitation
- Claim should remain open to allow completion of recommended treatment course

WHY INDEPENDENT MEDICAL OPINION IS REQUIRED

The parties are divided on whether 20 months post-injury and 14 months post-surgery represents a reasonable point for MMI determination in a case with documented CRPS complications; whether the 70% pain reduction achieved during a temporary spinal cord stimulator trial constitutes evidence of ongoing rehabilitation potential; whether authorization of permanent spinal cord stimulator implantation would be premature, or whether withholding this treatment in light of temporary trial success constitutes denial of reasonably necessary care; and what functional recovery, if any, can be realistically anticipated with permanent spinal cord stimulator implantation.

Contested Issue #3 — Reasonableness & Medical Necessity of Permanent Spinal Cord Stimulator

Issue statement. Whether permanent surgical implantation of a cervical spinal cord stimulator device is reasonable and medically necessary for management of CRPS Type I in this claimant, or whether the positive response to a temporary trial (70% pain reduction) does not justify the risks and costs of permanent implantation, and conservative pain management should continue.

HISTORY OF ISSUE

From October 2024 through January 2026 (months 7–22 post-injury), the claimant received multiple pain management interventions for CRPS Type I, including stellate ganglion block series, neuropathic pain medications, continued physical therapy, and psychological / behavioral health treatment. By January 2026, treating pain management specialists recommended evaluation for and trial of spinal cord stimulation based on inadequate response to medical management and documented functional impairment.

A temporary cervical spinal cord stimulator trial was performed in January 2026, resulting in approximately 70% pain reduction, improved sleep tolerance, and improved functional mobility.

Following the successful trial, treating providers recommended authorization for permanent implantable spinal cord stimulator device.

The carrier denied authorization for permanent implantation pending utilization review appeal process, characterizing permanent implantation as "premature."

CARRIER / INSURER POSITION

Dr. Pierce's November 18, 2025 IME (issued prior to the January 2026 trial) concluded that "permanent spinal cord stimulator implantation is premature." The carrier's subsequent denial reflects the position that temporary trial success does not automatically justify permanent device authorization, and that additional conservative pain management attempts should be mandated before permanent surgical intervention.

TREATING PROVIDERS' POSITION

- After 4+ months of optimized medical management with stellate ganglion blocks and neuropathic pain medications, functional improvement plateaued
- Temporary spinal cord stimulator trial demonstrated 70% pain reduction — a substantial and clinically meaningful response
- This level of pain reduction and functional improvement justifies progression to permanent implantable device
- Further delay in permanent implantation denies the claimant access to a treatment that has been proven effective in the claimant's case
- Permanent spinal cord stimulator implantation is the appropriate next step in the treatment algorithm for CRPS Type I when temporary trial is successful

WHY INDEPENDENT MEDICAL OPINION IS REQUIRED

The parties are divided on whether 70% pain reduction during a temporary trial constitutes sufficient evidence to justify permanent implantation; whether additional conservative trials should be mandated before permanent surgical intervention; whether the risks and long-term outcomes of permanent implantation are justified given the documented CRPS, post-surgical status, and functional limitations; what functional recovery and quality-of-life improvement can realistically be anticipated; and whether permanent implantation is a standard-of-care intervention for CRPS Type I when conservative management has failed and temporary trial demonstrates efficacy.

Contested Issue #4 — Current Work Capacity & Permanent Restrictions

Issue statement. Whether the claimant's current functional status permits return to any form of gainful employment (light-duty, sedentary, or modified-duty work), or whether documented

functional limitations from CRPS Type I and post-surgical shoulder pathology result in permanent total disability for any gainful employment.

HISTORY OF ISSUE

At time of injury, claimant was employed as Industrial Maintenance Technician — a position requiring overhead reaching, dexterity, strength, and ability to use hand tools and equipment. Post-injury, employer attempted to accommodate with restricted duty but was unable to find a suitable position within restrictions. Following shoulder surgery and CRPS development, functional decline was progressive.

In July 2025, a formal functional capacity evaluation documented no sustained overhead reaching capacity; maximum occasional lifting of 10 lbs only; marked reduction in right-hand dexterity; inability to perform repetitive gripping or tool usage; pain behaviors and guarding throughout evaluation. Employer confirmed permanent maintenance position unavailable.

In November 2025, the carrier IME (Dr. Randall Pierce) opined that "light-duty employment capacity exists with restrictions." The claimant remains off work as of March 3, 2026 (23 months post-injury), receiving temporary total disability benefits.

CARRIER / INSURER POSITION

Light-duty employment capacity exists with restrictions. Implication: return to some form of gainful employment is medically possible and appropriate; claimant is not permanently totally disabled. This opinion forms the basis of the MMI designation and suggests that benefits should transition from TTD to permanent partial disability once remaining permanency determination is finalized.

TREATING PROVIDERS' POSITION

- Functional capacity evaluation (July 2025) documented severe limitations incompatible with the claimant's pre-injury position
- Employer confirmed no suitable position available within the claimant's restrictions
- CRPS Type I has not resolved (as of March 2026, 23 months post-injury)
- Further functional improvement is uncertain pending outcome of proposed permanent spinal cord stimulator implantation
- Claimant appears to be permanently totally disabled or very limited in vocational capacity

WHY INDEPENDENT MEDICAL OPINION IS REQUIRED

The parties are divided on whether the FCE-documented functional limitations permit return to any gainful employment; what specific types of work, if any, fall within the claimant's documented functional capacity; whether light-duty or sedentary work is realistically available and sustainable for

a claimant with ongoing CRPS pain; what impact the proposed permanent spinal cord stimulator might have on functional capacity; and whether the claimant meets the legal definition of permanent total disability under Georgia workers' compensation law.

Contested Issue #5 — Appropriate Permanent Impairment Rating

Issue statement. Whether a permanent whole-person impairment (WPI) rating of 22%, as designated by the carrier IME, accurately reflects the claimant's permanent functional loss from the work-related shoulder injury and subsequent CRPS complication, or whether the AMA Guides application and / or CRPS-specific impairment assessment warrants a different rating.

HISTORY OF ISSUE

The claimant sustained a work-related right shoulder injury resulting in documented full-thickness rotator cuff tear with 3.2 cm retraction, partial infraspinatus tear, SLAP lesion, and AC joint arthropathy (MRI, April 2, 2024). Surgical repair was performed September 9, 2024. Post-operative CRPS Type I developed and was confirmed by March 2025 (12 months post-injury).

As of March 3, 2026 (23 months post-injury): CRPS Type I remains active and symptomatic; functional capacity remains severely limited; MMI status is disputed; claim remains open; permanent impairment rating has not been finalized or formally accepted by either party.

In the November 18, 2025 IME, Dr. Randall Pierce designated a permanent whole-person impairment rating of 22% WPI based on the shoulder pathology and post-surgical status.

ISSUES WITH RATING

- AMA Guides edition and methodology used by Dr. Pierce are not specified
- Whether CRPS Type I is included in the impairment calculation is unclear
- Whether 22% rating appropriately accounts for the dominant right upper extremity involvement is unclear
- Whether the rating is based on pre-MMI determination or post-MMI status is unclear

WHY INDEPENDENT MEDICAL OPINION IS REQUIRED

The parties are divided on whether 22% WPI appropriately reflects permanent functional loss from shoulder pathology and surgery alone; whether CRPS Type I should be incorporated into the impairment rating; what AMA Guides edition and methodology should apply; whether dominant right upper extremity involvement is appropriately weighted; whether impairment rating should be finalized given the recent positive spinal cord stimulator trial; and whether the 22% rating is consistent with documented severe functional limitations.

Section 5 — Records Provided for Review

CATEGORY	RECORDS
Emergency Department & Initial Treatment	ED evaluation March 12–18, 2024; radiograph reports (right shoulder, negative for fracture, soft tissue findings); ED physician notes; ambulance transport documentation
Imaging Studies	MRI right shoulder April 2, 2024 (full imaging report with radiologist interpretation, images if available); bone scan (October 2024–February 2025) — imaging report supporting CRPS Type I diagnosis
Conservative Care (April–July 2024)	Physical therapy records (30 visits); pain management consultation; subacromial corticosteroid injection documentation; prescription records; orthopedic provider records (Dr. Benjamin Ortiz consultation, August 14, 2024)
Surgical & Post-Op	Operative report September 9, 2024 (procedures, intraoperative findings, technical details, post-operative instructions); post-operative pain management; early follow-up notes (September–October 2024)
Post-Op Complication & CRPS (Oct 2024–Mar 2025)	Pain management records; stellate ganglion block procedures and records; neuropathic pain medication prescriptions and adjustments; neurology consultation records (March 2025); bone scan reports and interpretation; CRPS confirmation documentation
Rehabilitation & Functional Assessment (April–August 2025)	Continued PT records; Functional Capacity Evaluation July 2025 (complete report); employer work status correspondence (no available position confirmation)
Psychological & Behavioral Health	Psychological evaluation September 2025 (diagnostic assessment, MDD secondary to chronic pain); behavioral health treatment records
Pain Management & SCS Trial	Spinal cord stimulator trial documentation (January 2026): authorization and consent, temporary percutaneous lead placement procedure, trial period clinical notes (70% pain reduction documented), treating physician recommendations for permanent implantation

CATEGORY	RECORDS
Prior Independent Medical Examination	Carrier IME report — Dr. Randall Pierce, MD, November 18, 2025 (complete examination report, history, physical exam, diagnostic testing review, all opinions rendered)
Wage & Indemnity Documentation	AWW $1,742.66; Georgia statutory TTD rate $800/week (max applied); TTD benefit commencement March 19, 2024 (timeline reference only — financial detail excluded)
Claim Correspondence & Litigation	Claimant attorney information (Lauren Mitchell, Esq., Mitchell & Avery WC Law); administrative hearing order regarding benefit reinstatement; settlement discussion status

Outstanding items. Specific AMA Guides methodology from Dr. Pierce's 22% WPI rating; utilization review appeal documentation regarding permanent SCS denial (January 2026); any treating physician formal impairment rating opinion; additional neurology / pain management notes not previously summarized.

Section 6 — Questions for the Examining Physician

Based on the contested issues and medical chronology detailed above, please provide written medical opinions addressing the following specific questions:

QUESTION 1

Complex Regional Pain Syndrome — Diagnostic Validity, Objective Evidence & Work-Relatedness

The claimant was diagnosed with CRPS Type I approximately 12 months after the work-related shoulder injury (March 2025), with development of CRPS symptoms in the post-operative period from rotator cuff repair surgery. The carrier IME physician (Dr. Pierce, November 2025) noted that "objective evidence supporting severe CRPS remains limited."

(a) CRPS diagnostic certainty. Based on your review of the clinical presentation, diagnostic imaging (bone scan), pain management records, and neurology consultation records, do you agree with the diagnosis of Complex Regional Pain Syndrome Type I? Please explain your clinical reasoning.

(b) Objective evidence assessment. Please review the documented clinical findings (hypersensitivity, temperature changes, swelling, burning pain quality, bone scan findings, functional decline) and provide your assessment: is objective clinical and radiological evidence present that is consistent with CRPS Type I severity?

(c) Work-relationship and causation. CRPS Type I developed in the post-operative period after rotator cuff repair for a work-related injury. In your professional medical opinion, is the CRPS Type I a medically probable consequence of the work-related shoulder injury and surgical repair, or should it be characterized as unrelated or coincidental?

(d) Expected natural history. What is the typical natural history and prognosis of CRPS Type I when it develops as a post-operative complication of rotator cuff repair? What percentage of patients experience resolution, partial improvement, or persistent disability? What is the anticipated timeline for improvement or resolution?

QUESTION 2

Maximum Medical Improvement (MMI) Status — Appropriateness & Timing

The carrier IME (Dr. Randall Pierce) designated MMI effective November 18, 2025 (20 months post-injury, 14 months post-surgery), based in part on the opinion that "light-duty employment capacity exists." However, immediately following this MMI designation, the claimant underwent a temporary spinal cord stimulator trial in January 2026 that documented approximately 70% pain reduction and improved sleep tolerance.

(a) MMI determination timing. In your professional opinion, is 20 months post-injury and 14 months post-operative rotator cuff repair a reasonable time point for MMI determination in a case with documented post-operative CRPS Type I complications? Please explain the medical reasoning.

(b) Impact of spinal cord stimulator trial on MMI status. The claimant achieved approximately 70% pain reduction with improved sleep tolerance during the January 2026 trial (after MMI designation). Does this positive trial response indicate (i) that the November 2025 MMI designation was premature; (ii) that rehabilitation potential remains open pending permanent device implantation; or (iii) that the MMI designation remains appropriate despite the trial improvement? Please explain.

(c) Anticipated further functional recovery. If permanent spinal cord stimulator implantation is authorized and successfully implanted, what level of functional recovery and pain reduction would you anticipate based on published literature and clinical experience? What is the realistic potential for return to gainful employment?

(d) Ongoing claim activation. In your professional medical opinion, should this claim remain open and in "active treatment" status pending completion of permanent spinal cord stimulator implantation and post-implantation rehabilitation, or should it remain closed in MMI / permanent partial disability status?

QUESTION 3

Reasonableness & Medical Necessity of Permanent Spinal Cord Stimulator

The claimant's CRPS Type I has persisted for 18+ months without adequate relief from medical management alone. A temporary cervical spinal cord stimulator trial was performed in January 2026, resulting in approximately 70% pain reduction. Treating providers recommend permanent implantation; the carrier characterizes this as "premature."

(a) Trial success and permanence decision. A 70% pain reduction during temporary spinal cord stimulator trial is generally considered a positive or excellent response. Does this level of pain reduction during a temporary trial constitute sufficient medical evidence to support authorization of permanent implantation? Please reference published literature or clinical consensus if available.

(b) Medical necessity assessment. Based on the clinical facts (18+ months of CRPS Type I symptoms; failed medical management; 70% pain reduction on trial; severe functional limitations; major depressive disorder secondary to chronic pain), is permanent spinal cord stimulator implantation a reasonable and medically necessary intervention at this time?

(c) Risks, benefits, and alternatives. Please provide your assessment of expected benefits; known medical risks and complications; alternative treatments that should have been attempted; whether additional conservative trials are appropriate before permanent intervention.

(d) Prognosis with permanent device. If permanent spinal cord stimulator is implanted and properly optimized, what functional outcomes can the claimant realistically expect in terms of pain control, sleep quality, and return-to-work potential?

QUESTION 4

Current Work Capacity & Permanent Disability Status

The July 2025 FCE documented severe limitations (max 10 lbs occasional, no overhead reaching, marked dexterity loss, no repetitive gripping). The carrier IME opined that "light-duty employment capacity exists with restrictions." The claimant remains off work as of March 3, 2026.

(a) Functional capacity assessment. Do you agree or disagree with the carrier IME's opinion that light-duty employment capacity exists with restrictions?

(b) Specific work capacity. Given the documented functional limitations, what types of work activities, if any, fall realistically within the claimant's functional capacity? Be specific regarding lifting, dexterity, overhead reaching, repetitive activities, sustained gripping, cognitive vs. physical demands.

(c) Pre-injury position vs. current capacity. Is return to the Industrial Maintenance Technician position medically feasible? Are there substantially equivalent positions within the claimant's current functional capacity?

(d) Permanent total disability. Do the documented functional limitations and the persistence of CRPS Type I suggest the claimant meets the definition of permanent total disability, or is modified / alternative work realistic?

(e) Impact of spinal cord stimulator. If permanent spinal cord stimulator is implanted successfully, do you anticipate improvement in functional capacity sufficient to enable return to gainful employment?

QUESTION 5

Appropriate Permanent Whole-Person Impairment Rating Under AMA Guides

The carrier IME assigned a permanent whole-person impairment rating of 22% WPI. The specific AMA Guides edition, methodology, and factors are not detailed in the available IME report. Whether CRPS Type I is included in, excluded from, or separately calculated in the 22% WPI determination is unclear.

(a) AMA Guides methodology. Specify which edition (5th, 6th, etc.) you believe should be applied; what body part classification applies; what objective findings and functional testing should drive the rating.

(b) Shoulder impairment rating (excluding CRPS). Based on the documented post-operative status of rotator cuff repair, what permanent impairment rating would you assign to the right shoulder pathology and surgical repair alone, using appropriate AMA Guides methodology?

(c) CRPS Type I impairment assessment. Is CRPS Type I separately rated under AMA Guides? If so, what impairment rating applies? If CRPS is considered a complication of the shoulder injury, should it increase the overall impairment rating beyond the shoulder-specific rating?

(d) Dominant extremity consideration. The claimant's right arm is the dominant extremity. How does this factor affect the impairment rating?

(e) Reasonableness of 22% WPI. Based on your review, is 22% WPI appropriate, low and should be increased, or high and should be decreased?

(f) Consistency with functional impairment. Is a 22% WPI rating consistent with or contradictory to the documented severe functional limitations?

QUESTION 6

Relationship Between Documented Functional Limitations & Current Treatment Status

The claimant has documented severe functional limitations as of July 2025 that have not substantially improved as of March 2026, despite multiple interventions. The carrier designated MMI in November 2025 but opposed permanent SCS as "premature." When a temporary trial was authorized in January 2026, it demonstrated 70% pain reduction.

(a) Rationale for opposing permanent SCS. What medical factors typically justify withholding permanent SCS authorization when temporary trial has not yet been performed? Now that temporary trial has demonstrated 70% pain reduction, do those prior objections remain medically valid?

(b) Permanence of trial results. Based on the 70% pain reduction during the temporary trial, what is the realistic probability that a permanent implant would provide durable long-term pain control over 1, 2, and 5+ years?

(c) Sequencing of interventions. Is this sequence (conservative care → surgery → post-op pain management → CRPS management → temporary SCS trial → permanent implant pending) medically appropriate and consistent with standard-of-care treatment algorithms for post-operative CRPS Type I? Are there additional conservative measures that should have been attempted?

(d) Medical coherence assessment. The carrier IME simultaneously: acknowledged work-related shoulder injury; supported surgical repair; designated MMI; opposed permanent SCS as premature. Is it medically coherent to acknowledge a significant work-related injury requiring surgery, AND find MMI with persistent severe functional limitations, AND oppose continuation of active pain management interventions that have demonstrated efficacy?

QUESTION 7

Psychological Component & Relationship to Pain Management

The claimant underwent a psychological evaluation in September 2025 (18 months post-injury), resulting in a diagnosis of major depressive disorder secondary to chronic pain and occupational disability.

(a) Depression relationship to CRPS. Is major depressive disorder a common and expected psychological consequence of CRPS Type I when it persists for 18+ months with severe functional limitations? Please explain the psychosocial mechanism.

(b) Impact on recovery potential. Does the presence of major depressive disorder affect the prognosis for recovery with spinal cord stimulator implantation and rehabilitation? Should psychological treatment be optimized before or concurrent with permanent implantation?

(c) Pain behavior interpretation. The July 2025 FCE noted "pain behaviors and guarding throughout evaluation." Given the documented MDD diagnosis, should pain behaviors be interpreted as (i) valid indicators of functional limitation related to CRPS; (ii) potentially amplified by psychological distress; (iii) both physical pain and psychological amplification? How does this affect your assessment of true functional capacity?

Closing

Please provide your comprehensive written examination report addressing each of the questions above, along with any additional medical opinions relevant to the contested issues in this claim.

Your report should include:

- Complete description of your examination methodology and objective testing performed
- Detailed physical examination findings
- Assessment of medical records and prior testing
- Specific responses to each question above with medical reasoning
- Final opinions on causation, treatment necessity, MMI status, work capacity, permanency rating, and recommended care
- Any limitations of your examination or inconsistencies in the medical record that affect your opinions

Submit report to: Melissa Grant, Claims Examiner, Summit Ridge Casualty Insurance, Atlanta Catastrophic Claims Unit, ext. 2874.

Required timeframe for report delivery: Per Georgia state requirement (typically 30 days from examination date).

Action Plan for Adjuster

1 Physician Selection & Engagement (3–5 business days)

Specialty. Orthopedic Surgery, Physiatry (Physical Medicine & Rehabilitation), or Pain Medicine with expertise in CRPS and spinal cord stimulation. Board certification required. Experience with workers' compensation IME examinations required. No prior involvement in this claim (impartiality requirement).

Preferred qualifications. Experience with CRPS Type I evaluations; familiarity with spinal cord stimulator indications and outcomes; AMA Guides certification or demonstrated expertise in impairment rating; experience testifying in workers' compensation litigation.

Contact & engage. Telephone call with case overview; confirm availability and 30-day report timeline; verify no conflicts of interest; confirm preferred record format.

2 Record Compilation & Transmission (3–5 business days of physician engagement)

Using Section 5 as checklist, compile complete medical file including all ED records, MRI / bone scan imaging with reports, all 30 PT visits, pain management records and procedure notes, operative report, post-op follow-up, neurology and psychological evaluations, complete FCE report, SCS trial documentation, prior IME report, treating provider correspondence.

Verify completeness. Confirm all chronology dates supported by actual records; identify gaps; obtain missing records before transmission.

Organize chronologically. Clear folder / file structure with date and provider labels; index sheet; ensure legibility. **Remove all financial information** — medical documents only.

Transmission. Per physician's preference; include accompanying letter, examination authorization form, HIPAA consent if required, document index, contact information. Maintain transmission log.

3 Notice Obligations to Claimant & Attorney

Notice to claimant's attorney (Lauren Mitchell, Esq.): claim number, examining physician (name, specialty, address, phone), examination date / time / location; rights to attend, have representative present, request recorded record, receive copy of completed IME report; opportunity to identify additional records.

Timing. Send notice at least 10 business days prior to scheduled examination.

Notice to claimant directly if unrepresented or per carrier protocol: same content sent to Denise Harper, 4916 Red Clay Drive, Macon, GA 31210.

4 Examination Scheduling (within 2 weeks of physician engagement)

Coordinate with physician; schedule date, time, location; confirm claimant attendance. Notify all parties (attorney, claimant, physician's office) of details. Provide claimant with location, parking, arrival time, identification requirements, clothing instructions if applicable.

5 Pre-Examination Preparation

Authorization / payment. Confirm fee structure (hourly rate, minimum, report delivery charge); provide payment authorization per carrier policy.

Verify cooperation. Consider likelihood of refusal given litigation status; ensure attorney has been notified of examination rights and duty to cooperate; document attempted cooperation efforts.

Brief examining physician. Phone or email clarifying the five key contested issues (CRPS severity, MMI status, SCS necessity, work capacity, impairment rating). Reference Section 4. Clarify focus on these specific disputes.

6 Post-Examination Report Management

Set diary for report receipt (30 days post-examination per Georgia requirements); create follow-up tickler. Upon receipt, review for completeness of answers to all questions; consistency with medical record; clarity of medical opinions; basis for opinions stated. Flag areas requiring clarification or supplemental inquiry.

Identify consistency / conflict with prior IME (Dr. Pierce). Compare opinions on CRPS severity, MMI, work capacity, SCS necessity, WPI rating. Note areas of agreement and disagreement.

7 Claims Handling Decisions Based on IME Findings

If new IME agrees with carrier position: use new IME to support benefit dispute or MMI closure; prepare settlement / closure documentation.

If new IME agrees with treating providers: reassess strategy; consider authorizing recommended treatment (SCS); evaluate settlement position; consult coverage counsel re: litigation risk.

If middle position: identify specific areas of remaining disagreement; consider additional targeted IME (pain management for SCS, vocational expert, impairment rating specialist) for unresolved issues; evaluate settlement based on common ground.

8 Notice of IME Report Findings to Claimant & Attorney

Provide copy of IME report to claimant's attorney upon receipt and internal review (Georgia law typically requires timely notice). Document transmission. Brief letter explaining how findings will impact claims decisions; avoid argumentative language. If recommending closure, outline basis and appeal rights.

9 Claims Closure or Continuation Decision

Closure. File MMI / closure documents per Georgia statutory requirements; calculate PPD per Georgia formula using assigned WPI; notify claimant / attorney with appeal rights; address pending authorizations (SCS appeal) in closure.

Continuation. Issue treatment authorization (if medical necessity established); maintain active claim status pending completion of authorized treatment; set next review date (post-SCS implantation and rehabilitation).

10 File Documentation & Diary Management

File all IME-related documents (this letter, transmission log, examination authorization, notice to claimant / attorney, scheduled examination confirmation, completed IME report, internal review notes, follow-up correspondence with examining physician, claims decision memo).

Diary dates. Report receipt deadline (30 days); claims decision deadline if closure contemplated; post-treatment review (3–6 months post-implantation if SCS implanted); appeal deadline per Georgia statute.

Critical Reminders for Adjuster

- **Physician selection.** Complex case (CRPS, spinal cord stimulator, permanency rating). Select examining physician with genuine expertise — not a general orthopedic surgeon unfamiliar with CRPS or pain management.
- **Record accuracy.** Every fact in Section 3 has been extracted from the documents provided. Before transmitting to the examining physician, verify each date and finding is supported by the actual medical record. Do not add speculation or inferred information.
- **Exclude financial data.** Remove all reserve information, payment logs, indemnity calculations, and legal expense documentation. The examining physician needs clinical facts only.
- **Question specificity.** The seven questions in Section 6 are tailored to this file's disputed issues. Do not substitute generic boilerplate.
- **Attorney cooperation.** Provide professional courtesy and timely notice to Lauren Mitchell, Esq. Failure to provide adequate notice may support future litigation claims of improper procedure.
- **Timeline sensitivity.** Active litigation with settlement discussions ongoing. The IME report may be the pivotal document influencing settlement value.
- **Spinal cord stimulator authorization.** Key contested treatment. The IME's medical opinion will likely determine whether the carrier appeals the utilization review denial or authorizes treatment. This issue deserves thorough exploration.
- **Follow-up with physician.** If the IME report is unclear on any of the five contested issues, contact the examining physician promptly. A phone call is often more efficient than written correspondence.

DOCUMENT CLASSIFICATION

This is a Medical-Legal IME Examination Request Packet for workers' compensation. Prepared by AxiomAI Resolve based solely on documented medical records provided. The examining physician should view this letter not as advocacy for the carrier's position, but as a request for objective, expert medical opinion on specific, unresolved clinical issues critical to claim resolution.

To run this analysis on your own case, visit myaxiomai.com.