

Case Number:	CM13-0046129		
Date Assigned:	12/27/2013	Date of Injury:	02/08/2012
Decision Date:	02/28/2014	UR Denial Date:	10/31/2013
Priority:	Standard	Application Received:	11/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 31-year-old male who reported a cumulative trauma on 02/08/12. The patient reported that his regular work duties required him to move concrete and run a jackhammer and other similar duties which resulted in right elbow pain. The patient followed up on 03/20/12 with continued complaints of pain in the right lateral epicondyles. Examination revealed swelling and decreased handgrip. On 05/31/12, the patient was treated with a steroid injection to his right elbow. The patient was recommended for physical therapy on 06/25/12 by [REDACTED] for his diagnosis of tennis elbow. Per note from [REDACTED] stated on 12/20/12, the patient had completed 7 of 8 sessions of physical therapy and reported continued pain in his elbow and weakness in the right arm. An examination revealed handgrip was markedly diminished. There was tenderness noted over the lateral epicondyle scar on the right. The patient had limited extension to 60 degrees and it was noted that there was an obvious size difference in the forearm muscles. A work hardening program was requested to increase range of motion and strength. In [REDACTED] office note dated 01/23/13, there was mention that the patient had completed physical therapy and that a work hardening program was not approved. The patient was seen by [REDACTED] for consultation on 01/23/13. The provider noted that the patient initially developed a small lump of tissue on the lateral side of his elbow. An orthopedic surgeon did not recommend surgery and he was treated with one cortisone shot which did not improve his symptoms. He was also treated with approximately 30 sessions of physical therapy. He ultimately underwent surgery in August 2012. He developed a clicking in the elbow and underwent subsequent surgery for this in October 2012. He presented on 01/23/13 with significant pain around the lateral aspect of the right elbow. X-rays taken demonstrated normal bony mineralization for age. Joint spaces appeared well preserved with only minor arthritic changes at the level of Ulna-humeral joint medially. The medial condyle was relatively large, but

there are no enthesophytes on the medial aspect of the elbow. The lateral distal humeral cortex is mildly rough consistent with his previous surgery. A right elbow MRI and additional injections were recommended. Additional surgery was not felt to be beneficial at that time. MRI of the right elbow without contrast was obtained on 02/15/13 which revealed subtle hyper-intensity along the origin of the common extensor tendon, mild synovial effusion in the elbow joint and subcutaneous edema around the elbow joint. On 03/26/13, the patient was seen by [REDACTED] [REDACTED] for a Qualified Medical Examination. The patient had complaints of constant pain in the right arm and elbow rated at a 7/10. The patient's diagnoses includes re-rupture of common extensor tendon, right elbow, suture reaction to right hand stretch from repair, extensor mechanism, posterior interosseous nerve syndrome, and entrapment of posterior interosseous nerve in the supinator muscle. [REDACTED] noted that the patient had significant symptomatology and objective findings with disability related to lateral epicondylar tendinitis in the right elbow. There was question if the patient had reaction to the Vicryl suture use in the repair or if the repair itself actually ruptured from its origin. The provider recommended an EMG and conduction studies on the right elbow, re-exploration of right elbow, and possible arthrogram to enhance the diagnosis possibilities of extensor tendon .rupture. He also recommended that the elbow be re-explored by second opinion with a qualified orthopedic surgeon. In [REDACTED] 04/19/13 office note he made mention to his previous assessment of recalcitrant right elbow lateral epicondylitis that had not responded to previous treatment. The patient mentioned that surgery was recommended in a Qualified Medical examination, but he could not specify what surg

IMR ISSUES, DECISIONS AND RATIONALES

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

outpatient right stellate ganglion block with fluoroscopy and sedation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Stellate Ganglion Block Page(s): 105.

Decision rationale: Regarding the Stellate ganglion blocks requested for this patient, these blocks are thought to be most beneficial when used early in the disease as an adjunct to rehabilitation with physical or occupational therapy, considering the chronicity of the patient CRPS, it is doubtful that this procedure will provide any benefit. Recommended for limited, select cases, primarily for diagnosis of sympathetically mediated pain and therapeutically as an adjunct to facilitate physical therapy/ functional restoration. Long duration of symptoms prior to intervention is associated with poor response. The use of sedation with the block can influence results, and this should be documented if utilized. . In this case, the documentation lacks evidence to support the diagnosis of CRPS such as continuing pain, which is disproportionate to the inciting event, allodynia, temperature asymmetry, and skin color changes, edema, decreased range of motion. For instance [REDACTED] on medical report dated 08/22/13 for a new patient evaluation and treatment of his injured right upper extremity. "He reported pain in his right arm and elbow rated at an 8/10. On physical examination, the patient could flex his right arm to 40 degrees at the elbow and 15 degrees farther laterally than the left arm. The right arm

was slightly redder in color than the left. There was decreased range of motion at the left shoulder. There was abnormal sensation over the extensor tendons down to the wrist, mild swelling but no allodynia, plus hyperalgesia. He had dystonia at the elbow with partial flexion and inability to fully spread fingers and extend the wrist past 45 degrees on the right. There was no temperature, skin, or hair growth change. There was decreased sensory exam to pinprick in the right thumb, 3rd and 5th fingers, and medial forearm. A right stellate ganglion block was recommended as a diagnostic/therapeutic trial." In addition the documentation lacks evidence that supports exercise, rehabilitation, and other physical methods geared towards improving and maintaining functionality have been tried and failed. Therefore, the request for outpatient right stellate ganglion block with fluoroscopy and sedation with CPT codes 64510 (Injection for nerve block), 77003 (Fluoroguide for spine inject), 99144 (Moderate sedation) is not medically necessary.