MAXIMUS Federal Services

Case Number:	CM13-0063520		
Date Assigned:	03/03/2014	Date of Injury:	01/16/2013
Decision Date:	05/26/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/09/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty 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 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/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:

The patient is a 63 year old male who was injured on 01/16/2013. He was fixing a forklift when he went to lower it. His thumb got caught. In desperation, he tried to pull it out. Prior treatment history has included 12 occupational and hand therapy sessions, 7 sessions of physical therapy. The patient underwent a left stellate ganglion block injection on 09/27/2013. Diagnostic studies reviewed include EMG/NCV dated 12/18/2013 revealed an abnormal EMG and nerve conduction study of the right upper extremity consistent with a severe right carpal tunnel syndrome secondary to significantly delayed median motor and sensory latencies across the wrists and moderate to severe right ulnar neuropathy at both the elbow and wrist with conduction delay seen across these segments. There was no evidence of radial neuropathy or cervical radiculopathy. PR2 dated 11/26/2013 documented objective findings to reveal his thumb opponens splint was in place. There was numbness in the left ring and little fingers and he elevated his left arm again with no evidence of tremor. After asking him to elevate his shoulder, a mild tremor occurred but not nearly as severe as previous. The patient was diagnosed with Autonomic Nerve Dis OT, left shoulder hand syndrome, digit crushing injury and left thumb surgery 1/16/2013. PR2 dated 11/12/2013 reported the patient was in a cloth sling without a posterior splint that he used for a minimum of two months and did not mobilize his left upper extremity. He was complaining of progressive and increasing disuse of that upper extremity associated with tremors on a functional use, and pain that has now migrated from his hand into his forearm, upper extremity and into his left shoulder. There was a side to side difference as far as coolness on the left upper extremity compared to the right side with significant pain that did not allow him to use his arm in any functional way. He stated he felt numbness and tingling and paresthesias in the fourth and fifth digits of his hand and the same

distribution into the shoulder. He had a non-functional left thumb. A pain anesthesiologist, who had performed a stellate block back in the end of August, noted he did not describe increased warmth following the injection but he had significant relaxation of his muscles that allowed him to fully extend his left upper extremity that he held in a contracture and posture that is flexion. He complained of increasing pain. On examination, he tended to only use his fourth and fifth digits of that left hand. There was atrophy in the hypothenar eminence and intrinsics compared to the right side. There was sheen to the skin on the hand and to the undersurface of the forearm compared to the right side. His sensation showed that there was increasing pain with stimulation including pin roll. The sensation remained after the stimulus was removed. There was blanching of the fingertips and there again no discoloration noted. He had limited range of motion when we attempted to move it to 90 degrees on forward elevation. He refused to abduct that arm and could then generate a tremor. He had pain with deep sensation and grabbing the muscles. His range of motion of the neck and other neurological findings were within normal limits. The patient was diagnosed with status post crush injury to the left thumb that was treated with external fixator and immobilized for 2 months in a sling that he held closely to his chest, disuse function of the left upper extremity secondary to #1, complex regional pain syndrome type 1 secondary to #1 and #2, pain disorder; psychogenic tremor and rule out dystrophic tremor. The recommendation was to obtain a limited bone scan of the upper extremities and consideration for repeat on a more regular and scheduled basis of every coupled with physical therapy but only graduated; along with consideration for a comprehensive pain management program. On October 29/2013, he continued to note pain of the left thumb with motion of the IP joint as well as pain of the left ring and little fingers which radiated to the upper arm and shoulder. Examination of the shoulder and hand were noted to be much improved. He was able to elevate his shoulder greater than 100 degrees but then his tremor begins. His elbow and wrist did not initiate the tremor. He was wearing his opponens thumb splint and his finger motion was excellent.

IMR ISSUES, DECISIONS AND RATIONALES

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

A SERIES OF THREE LEFT STELLATE GANGLION NERVE BLOCKS UNDER FLUOROSCOPY: 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): 103 and 108.

Decision rationale: According to the California MTUS guideline, stellate ganglion block has limited evidence to be supported, with most studies reported being case studies. This block is proposed for the diagnosis and treatment of sympathetic pain involving the face, head, neck, and upper extremities. The medical records document diagnosed with CRPS and had Stellate injection dated 9/27/2013, the PR was dated 10/29/2013 revealed the patient had continued to note pain in the left thumb of IP joint as well as pain of the left ring and little fingers which radiated to the upper arm and shoulder, though there was improvement of ROM. As this procedure is experimental and there was no obvious benefit gained from the prior procedure, the request is not medically necessary according to the guidelines.