Case Number:	CM14-0018346		
Date Assigned:	06/20/2014	**Date of Injury:**	11/20/2011
Decision Date:	08/12/2014	**UR Denial Date:**	02/05/2014
Priority:	Standard	**Application Received:**	02/13/2014

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 & Rehabilitation 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 injured worker is a 53-year-old female who reported an injury on 11/20/2011 due to repetitive scooping. The injured worker had a status post left elbow ulnar nerve revision decompression neurolysis on 05/29/2013, status post left ulnar nerve decompression, partial medial epicondylectomy, and interior subcutaneous transposition of the ulnar nerve dated 06/13/2012. The diagnostics included electromyogram and nerve conduction studies of the upper extremities that were performed in 2012 and an MRI and x-ray was obtained in 2013. The injured worker received physical therapy on unknown dates. The past treatment included injections to the elbow, wrist, and neck with no dates given and 12 visits of physical therapy. The physical therapy note dated 05/29/2013 revealed objective findings to the left elbow with decreased sensation. The exercise activities included forearm pronation with 3 set of 10 repetitions for 4 minutes, forearm supination with 3 sets of 10 repetitions for 4 minutes and isotonic activity of Digi Flex with 4 minutes of relapse. The objective findings dated 05/27/2014 also revealed muscle testing to the left upper extremity: forearm pronation at 4/5 on the left, forearm supination at 4/5, wrist extension at 4/5, and wrist flexion at 4/5; right upper extremity revealed forearm pronation at 4+/5, forearm supination 4+/5, wrist extension 4+/5, and wrist flexion 4+/5. The medications included Gabapentin, Voltaren gel, and Lidoderm patches, with a reported 8/10 pain to the left elbow using the VAS. Per the clinical notes dated 05/12/2014, the treatment plan included the stellate blocks, implantation of a stimulator, and 12 therapy sessions. The request for authorization form dated 06/20/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Stellate Ganglion Block Series Of Three: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Stellate Ganglion Block.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regional Sympathetic Blocks Page(s): 103.

Decision rationale: The California MTUS Guidelines recommend that the stellate ganglion block be limited to the diagnosis and treatment for complex regional pain syndrome. The block is proposed for the diagnosis and treatment of sympathetic pain involving the face, head, neck, and upper extremities when associated diagnoses of complex regional pain syndrome, herpes zoster, and postherpetic neuralgia. Per the clinical notes provided, the injured worker did not have a diagnosis of complex regional pain syndrome. The objective findings per the clinical notes provided indicated that the injured worker was able to perform and tolerate the exercise activities with no complaints or pain. As such, the request is not medically necessary.