

<b>Case Number:</b>	CM14-0184545		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	05/19/2010
<b>Decision Date:</b>	12/16/2014	<b>UR Denial Date:</b>	10/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2014

### 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 Internal Medicine 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:

This is a case of a 42 year old female with a date of injury of 5/19/2010. In a pain management note by [REDACTED] dated 9/23/2014, the patient presented with right arm pain, right arm tingling, right arm burning, right arm "pins & needles" sensation and right arm weakness. The patient has right wrist pain since 5/19/2010 and was diagnosed with reflex sympathetic dystrophy. She has had multiple surgeries on the right wrist, cortisone injections x 4, physical therapy, occupational therapy, acupuncture, along with using NSAIDs and Vicodin without success, in fact, she is having worsening pain since 2010. She notes that pain radiates from the first 3 digits of her hand to her elbow and shoulder. There is swelling, temperature change, numbness, a "clammy" sensation, and nail changes in the right hand compared to the left. Pain is worse at night. On physical examination, she is in mild to moderate distress. She has grimacing with teeth clenched, moaning and groaning with guarded movements, limited mobility and still movements. Activity restrictions include grasping on the right, grasping and twisting on the right, repetitive movements with the right upper extremity, especially overhead motion, typing and chart manipulation. Tenderness to palpation with allodynia on the right wrist along the anatomic snuff box, and hyperpathia Also noted was tenderness along the right lateral epicondyle, tenderness to palpation with muscle twitch response at the right pectoralis minor and right scalene muscles. Adson's was markedly positive. He right shoulder is internally rotated and elevated. Tenderness to palpation with muscle twitch response in the right parascapular musculature was also evident. Her right upper extremity gave way to strength due to pain and allodynia in the right wrist and hand. Strength of the major muscle groups were noted to be 4/5. She is diagnosed with chronic pain, brachial plexus lesions, brachial neuritis/radiculitis not otherwise specified, unspecified neuralgia neuritis and radiculitis, complex region pain syndrome, neurovascular compression, radial neuralgia and thoracic outlet syndrome. Treatment

requested was ultrasound of the right wrist with possible radial nerve block, ultrasound of the right brachial plexus with possible pectoralis minor and right stellate ganglion block.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Ultrasound R Brachial Plexus w/ possible Pectoralis Minor: 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 Section 9792.20 Page(s): 103-104. Decision based on Non-MTUS Citation PubMed. Gov On Line version. Vasc Endovascular Surg. 2011 Jan;45 (1):33-8. Recurrent Neurogenic thoracic outlet stressing the importance of pectoralis minor syndrome.

**Decision rationale:** Based on MTUS guidelines, regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, & lumbar sympathetic block) recommendations are generally limited to diagnosis and therapy for complex regional pain syndrome (CRPS). There is limited evidence to support stellate ganglion block (cervicothoracic sympathetic block). The stellate ganglion is formed by a fusion of the inferior and first thoracic sympathetic ganglia in 80% of the patients. In the other 20%, the first thoracic ganglion is labeled the stellate ganglion. The proposed indications for this block is for the diagnosis and treatment of sympathetic pain involving the face, head, neck and upper extremities. Pain from CRPS, herpes zoster and post-herpetic neuralgia as well as frostbite are all possible indications. Thoracic Sympathetic Blocks are not recommended due to lack of literature to support effectiveness. It is utilized for sympathetic blocks of the upper extremity in the 20% of individuals with innervation of the upper extremity by Kuntz's nerves (nerves from the 2nd and 3rd thoracic sympathetic ganglia bypass the stellate ganglion and directly join the brachial plexus). Proposed indication are for CRPS, peripheral neuropathy, brachial plexalgia, sympathetically maintained pain and vascular disorders. In an article published in Vascular Endovascular Surgery 2011, they concluded that all patients with neurogenic thoracic outlet syndrome should be evaluated clinically for Neurogenic pectoralis minor syndrome. If patients complain of pain or tenderness in the anterior chest wall and axilla, a diagnostic pectoralis minor muscle block should be performed. A good response to the block suggests that consideration be given to performing pectoralis minor tenotomy alone as it is a simple, low-risk outpatient procedure. If unsuccessful, brachial plexus decompression can be performed at a later date. If there is a poor response to the pectoralis minor muscle block, brachial plexus decompression is indicated alone with pectoralis minor tenotomy, provided there were some symptoms of Neurogenic pectoralis minor syndrome. Basically, both stellate ganglion blocks and thoracic sympathetic blocks are not recommended. In this case the request is for ultrasound of the right brachial plexus with possible pectoralis minor injection. It is unclear if this is for diagnostic or therapeutic intervention. Since the treatment plan is not clearly outlined and the request is not complete, the request for ultrasound of the right brachial plexus with possible pectoralis minor injection is not medically necessary.

#### **R Wrist Possible Radial Nerve Block: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Forearm, Wrist, and Hand Chapter; Ultrasound (diagnostic)

**Decision rationale:** Based on ODG guidelines, the indications for a radial nerve block include: surgical anesthesia along the course of the radial nerve, supplement to brachial plexus block, postoperative analgesia, acute pain emergencies in the course of the radial nerve, radial tunnel syndrome, or cheiralgia paresthetica or Wartenberg syndrome. In this case it appears that the request for a right wrist ultrasound with possible radial nerve block was already approved and this is a duplicate request. Therefore this request for a right wrist ultrasound with possible radial nerve block is not medically necessary.