

<b>Case Number:</b>	CM13-0025970		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	06/25/2009
<b>Decision Date:</b>	02/11/2014	<b>UR Denial Date:</b>	09/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in New York and Texas. 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.

### 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 40-year-old female who reported an injury on 06/25/2009. The mechanism of injury was not provided. An initial injury was to her right lower extremity that resulted in complex regional pain syndrome. The patient is noted to have undergone a trial of a spinal cord stimulator which resulted in a dural tear with spinal fluid leak that was repaired with a laminectomy at L3. Since that time, the patient has continued to have significant neck pain and headaches that radiate to the left posterior arm. Duration to her persistent pain, the patient received and MRI of the cervical spine on 01/17/2013; the unofficial reports showed congenital narrowing of the spinal canal with no severe cord compression; however, at C6-7 there was severe canal stenosis and cord compression. The patient then underwent a cervical arthrodesis at C6-7, a discectomy with bilateral foraminotomy at C6-7, anterior spinal plating at C6-7, a placement of a PEEK biomechanical interbody spacer at C6-7, use of a DBX demineralized bone matrix for augmentation of fusion, and use of local bone autograft. It appears the patient had an unremarkable recovery from this operation but continued to complain of neck pain and experience migraine headaches. There was no other clinical information submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar sympathetic blocks on the right side at L2 and L3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 39,103. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lumbar Sympathetic Page(s): 57.

**Decision rationale:** The California MTUS Guidelines recommend lumbar sympathetic blocks for differential diagnosis and treatment of sympathetic pain involving the lower extremities. Guidelines state that for diagnostic testing, 3 blocks over a 3 to 14 day period is recommended. Positive response is indicated as pain relief of 50% or greater with associated functional improvement. The clinical records submitted for review do not contain any information as to why the lumbar sympathetic blocks are being requested. There is only minimal discussion of the patient's RSD to her right ankle/foot area; "she has not returned to work because of her chronic ankle pain/RSD and possibility of pending ankle surgery," on 05/30/2013. Without any details regarding the patient's RSD status or indication for the injections, the medical necessity of this request cannot be determined. As such, the request for lumbar sympathetic blocks on the right side at L2 and L3 is non-certified.