

<b>Case Number:</b>	CM13-0029381		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	11/17/2008
<b>Decision Date:</b>	08/11/2014	<b>UR Denial Date:</b>	09/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2013

### 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 injured worker is a 35-year-old female who reported an injury on 11/17/2008. The mechanism of injury was not provided for review. The injured worker ultimately developed chronic regional pain syndrome and underwent spinal cord stimulator implantation. The injured worker was evaluated on 10/09/2013. Physical findings included decreased range of motion of the lumbar spine with decreased motor strength of the bilateral lower extremities. The injured worker had decreased sensation in the right L5-S1 dermatomal distributions and decreased sensation in the left L4-5 on S1 dermatomal distribution. It was noted that the injured worker had hyperalgesia of the foot and ankles bilaterally with allodynia. It was noted that the injured worker had 10/10 pain without medications that was decreased to a 6/10 pain with medications and allow for increased mobility and tolerance of activities of daily living and home exercises. The injured worker's diagnoses included degenerative lumbar disc disease, reflex sympathetic dystrophy at the bilateral lower extremities, pain in ankle and foot joint, pain in the pelvic region and thigh region, and lumbago. A request was made for a test dose of an intrathecal pain pump to assist with pain control in conjunction with the spinal cord stimulator. A request was also made for a stellate ganglion block. However, no justification for that request was provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**INTRATHECAL PUMP TRIAL.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug delivery system/trials.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Intrathecal drug delivery systems, medications Page(s): 54.

**Decision rationale:** The requested intrathecal pain pump trial is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has a spinal cord stimulator. The Chronic Pain Medical Treatment Guidelines does support the use of intrathecal drug delivery systems for medications when oral medications fail to provide adequate pain management. The clinical documentation submitted for review does indicate that the injured worker has a spinal cord stimulator in conjunction with oral pain medications. The clinical documentation fails to provide any evidence that the injured worker's spinal cord stimulator has failed to provide adequate pain coverage. It is noted within the documentation that when the spinal cord stimulator was first implanted it was providing significant pain relief and allowing for medication reduction. The injured worker's most recent clinical evaluation documented that the spinal cord stimulator was causing pain. Revision of that spinal cord stimulator would need to be provided prior to insertion of an intrathecal pain pump or trial. As the potential for an adjustment to the spinal cord stimulator would provide adequate relief, the addition of an intrathecal pain pump trial would not be supported. As such, the requested intrathecal pain pump trial is not medically necessary or appropriate.

**STELLATE GANGLION BLOCK.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRPS/Stellate ganglion block.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Stellate ganglion block Page(s): 103.

**Decision rationale:** The requested stellate ganglion block is not medically necessary or appropriate. The Chronic Pain Medical Treatment Guidelines does recommend the use of stellate ganglion blocks to assist with pain control of complex regional pain syndrome. However, the request as it is submitted does not specifically identify where the stellate ganglion block will be administered to. Additionally, the clinical documentation fails to provide any evidence of treatment goals or aggressive physical therapy associated with this treatment. As such, the requested stellate ganglion block is not medically necessary or appropriate.