

Case Number:	CM13-0040618		
Date Assigned:	12/20/2013	Date of Injury:	07/23/1997
Decision Date:	02/05/2014	UR Denial Date:	09/26/2013
Priority:	Standard	Application Received:	10/29/2013

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 Pain Management, has a subspecialty in Disability Evaluation 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 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. 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 claimant is a 55-year-old woman with chronic pain syndrome of her right foot. Her proximal began after she broke her foot in 1985. She subsequently developed tarsal tunnel syndrome and had multiple procedures. Ultimately, she developed complex regional pain syndrome of her foot. She had a spinal cord stimulant placed in 2001 which was successful. She states that she has had 3 revisions since then for battery and migrated leads. Because of her pain, she had been using a wheelchair for the past year. She is able to walk with extreme difficulty. Patient has a history of chronic hypertension and coronary artery disease. She experienced an acute anterior myocardial infarction in 2002 and underwent placement of a stent to the left anterior descending coronary artery. She has not continued with cardiovascular outpatient care. On 6/7/2013, she was admitted with complaint of fever. Nonproductive cough, dizziness, weakness and mild left-sided chest discomfort. She denied urinary frequency. Urgency or dysuria. Chest x-ray revealed patchy opacities in the right lung. She was placed on intravenous antibiotics and vigorous fluid reo=placement therapy, she is up 3.5 liters since admission. On 6/10/2013, she complained of severe dyspnea and chest pain. Topical nitrates were applied and she was placed on nasal oxygen 5 liters per minuets. She became increasingly tachypneic. She continued to complain of chest pain. Electrocardiogram revealed sinus tachycardia with evidence for prior anteroseptal myocardial infarction but no acute ST segment elevation. Twenty milligrams of intravenous Lasix was administered with a modest dieresis, her respiratory distress increased, and she was transported to the coronary care unit where she is currently normotensive with blood pressure of 130/94, sinus tachycardia at 120 per minute is present. She was placed on BiPAP. Electrocardiogram was repeated and again revealed sinus tachycardia and evidence of a remote anteroseptal myocardial infarction, a

IMR ISSUES, DECISIONS AND RATIONALES

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

Sympathetic Nerve Block (Guanethidine Bier Block, right lower extremity) October 7, 2013: 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 Page(s): 24 and 39 of 127.

Decision rationale: CA-MTUS (effective July 18, 2009) section on Bier's Block, page 24 of 127, states: Recommended as an option with bretylium for severe CRPS. Due to modest benefits and the invasiveness of the therapy, intravenous regional sympathetic block (Bier's block) with bretylium should be offered only after careful counseling, and should be followed by intensive physical therapy. Although there is very limited scientific evidence to support this treatment, it is recommended as an option in certain cases when there are no other alternatives. When the procedure is performed, it must be done in conjunction with a rehabilitation program. Any additional blocks must be based on objective evidence of improvement. CA-MTUS on page 39 further stated: Sympathetic Block is recommended only as indicated below, for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. Recommendations for the use of sympathetic blocks are listed below. They are recommended for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. It should be noted that sympathetic blocks are not specific for CRPS. Repeated blocks are only recommended if continued improvement is observed. Systematic reviews reveal a paucity of published evidence supporting the use of local anesthetic sympathetic blocks for the treatment of CRPS and usefulness remains controversial. Less than 1/3 of patients with CRPS are likely to respond to sympathetic blockade. No controlled trials have shown any significant benefit from sympathetic blockade. (Varrassi, 2006) (Cepeda, 2005) (Hartrick, 2004) (Grabow, 2005) (Cepeda, 2002) (Forouzanfar, 2002) (Sharma, 2006) Predictors of poor response: Long duration of symptoms prior to intervention; Elevated anxiety levels; poor coping skills; Litigation. (Hartrick, 2004) (Nelson, 2006) Alternatives to regional sympathetic blocks: may be necessary when there is evidence of coagulopathy, systemic infection, and/or post-surgical changes. These include peripheral nerve and plexus blocks and epidural administration of local anesthetics. Mixed conduction blocks (central neural blocks): suggested when analgesia is insufficient by pharmacologic means to support physical therapy: (1) Implanted catheters at the brachial or lumbosacral plexus: allows for 1 to 2 weeks of therapy. Side effects include technical failure and infection; & (2) Epidural tunneled catheters: allows for long-term therapy: Side effects: same as above Segmental nerve injury; Hypotension (secondary to vasodilation); Bleeding; Paralysis: Renal puncture/trauma. Genitofemoral neuralgia can occur with symptoms of burning dysesthesia in the anteromedial upper thigh. It is advised to not block at L4 to avoid this complication. Adequacy of the block: This should be determined, generally by measure of skin temperature (with an increase noted on the side of the block). Complete sympathetic blockad

Sympathetic Nerve Block (Guanethidine Bier Block, right lower extremity) October 14, 2013: 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 Page(s): 24 and 39 of 127.

Decision rationale: The Physician Reviewer's decision rationale: CA-MTUS (effective July 18, 2009) section on Bier's Block, page 24 of 127, states: Recommended as an option with bretylium for severe CRPS. Due to modest benefits and the invasiveness of the therapy, intravenous regional sympathetic block (Bier's block) with bretylium should be offered only after careful counseling, and should be followed by intensive physical therapy. Although there is very limited scientific evidence to support this treatment, it is recommended as an option in certain cases when there are no other alternatives. When the procedure is performed, it must be done in conjunction with a rehabilitation program. Any additional blocks must be based on objective evidence of improvement. CA-MTUS on page 39 further stated: Sympathetic Block is recommended only as indicated below, for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. Recommendations for the use of sympathetic blocks are listed below. They are recommended for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. It should be noted that sympathetic blocks are not specific for CRPS. Repeated blocks are only recommended if continued improvement is observed. Systematic reviews reveal a paucity of published evidence supporting the use of local anesthetic sympathetic blocks for the treatment of CRPS and usefulness remains controversial. Less than 1/3 of patients with CRPS are likely to respond to sympathetic blockade. No controlled trials have shown any significant benefit from sympathetic blockade. (Varrassi, 2006) (Cepeda, 2005) (Hartrick, 2004) (Grabow, 2005) (Cepeda, 2002) (Forouzanfar, 2002) (Sharma, 2006) Predictors of poor response: Long duration of symptoms prior to intervention; Elevated anxiety levels; poor coping skills; Litigation. (Hartrick, 2004) (Nelson, 2006) Alternatives to regional sympathetic blocks: may be necessary when there is evidence of coagulopathy, systemic infection, and/or post-surgical changes. These include peripheral nerve and plexus blocks and epidural administration of local anesthetics. Mixed conduction blocks (central neural blocks): suggested when analgesia is insufficient by pharmacologic means to support physical therapy: (1) Implanted catheters at the brachial or lumbosacral plexus: allows for 1 to 2 weeks of therapy. Side effects include technical failure and infection; & (2) Epidural tunneled catheters: allows for long-term therapy: Side effects: same as above Segmental nerve injury; Hypotension (secondary to vasodilation); Bleeding; Paralysis: Renal puncture/trauma. Genitofemoral neuralgia can occur with symptoms of burning dysesthesia in the anteromedial upper thigh. It is advised to not block at L4 to avoid this complication. Adequacy of the block: This should be determined, generally by measure of skin temperature (with an increase noted on the side)