Case Number:	CM13-0042449		
Date Assigned:	12/27/2013	**Date of Injury:**	01/01/2013
Decision Date:	02/27/2014	**UR Denial Date:**	09/18/2013
Priority:	Standard	**Application Received:**	10/18/2013

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, Maryland, Florida and Distric of Columbia. 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 patient is a 20 year old female with a history of a work related injury to her neck and left arm on 1-1-13 after a fall. The patient complains of pain in the left upper extremity and in the neck with pain level of 8/10 despite oxycodone and recent left stellate ganglion block. Patient other medications include Amitriptyline, Gabapentin, and Terazosin. She has limited use of the left arm. She states that the pain has stayed about the same since injury. The pain is made worse with nothing in particular. Sleep disturbance due to pain is occasional. Physical examination revealed Motor 5/5 in all muscle groups tested and normal sensation to light touch. Palpation over the left upper extremity does reproduce pain symptoms. There is skin mottling and allodynia to touch. Range of motion is restricted in the left shoulder, elbow, wrist and hand. She was diagnosed with Cervicalgia and Complex regional pain syndrome (CRPS I) of the left arm. The issue is whether a diagnostic and potentially therapeutic left brachial plexus block under ultrasound is medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

URGENT LEFT BRACHIAL PLEXUS BLOCK UNDER ULTRASOUND: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 103.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRPS Page(s): 41.

Decision rationale: The patient has been on several pharmacologic agents including, Amitriptyline, Gabapentin, and Terazosin. The patient is a non responder to sympathetic blocks, as documentation showed patient previously underwent a stellate ganglion block without benefit. As stated above, "For non-responders somatic block or epidural infusion may be required to optimize analgesia for PT". Left brachial plexus block is a type of somatic block performed with ultrasound to guide the needle to the correct location. Patient has been prescribed Physical Therapy; therefore left brachial plexus block under ultrasound is medically necessary. CA-MTUS (Effective July 18, 2009) page 41 of 127, section on CRPS, pain management: (a) Pharmacological: antidepressants (particularly amitriptyline); anticonvulsants (particularly gabapentin); steroids; NSAIDS; opioids; calcitonin; bisphosphonates; Î±1 adrenoceptor antagonists (terazosin or phenoxybenzamine). The latter class of drugs has been helpful in SMP. Clonidine has been given transdermally and epidurally. (See CRPS, medications.) Bisphosphonates have some literature support in the presence of osteopenia. (Rho, 2002) (b) Minimally invasive: depends on degree of SMP, stage of rehabilitation (passive or active movement), and response to blocks. (See CRPS, sympathetic blocks.) Responders to sympathetic blocks (3 to 6 blocks with concomitant PT) may be all that is required. For non-responders somatic block or epidural infusion may be required to optimize analgesia for PT. (c) More invasive: After failure of progression or partial relief, consider tunneled epidural catheters for prolonged sympathetic or somatic blocks or neurostimulation with SCS in CRPS-I and II. See CRPS, spinal cord stimulators. Also consider peripheral nerve stimulation in CRPS-II and intrathecal drug delivery in patients with dystonia, failed neurostimulation, longstanding disease, multi-limb involvement and requirement of palliative care.