

Case Number:	CM13-0066951		
Date Assigned:	01/03/2014	Date of Injury:	01/26/2001
Decision Date:	05/21/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	12/17/2013

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 & Rehabilitation has a subspecialty in Pain 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:

The injured worker is a 45-year-old female who sustained a work-related injury on 01/26/2001. Patient sustained a traumatic tendon tear of the right foot with Lisfranc fracture, complex regional pain syndrome, and depression secondary to chronic pain. Patient underwent surgical repair for the fracture in 2001, since then she developed right foot pain and swelling. Right sided lumbar sympathetic block was performed on 3/12/2012 at L2 and L4 level with improvement of her symptoms. Patient also had brief trials of Zonergan, Suboxone, Toradol injection intramuscularly, Cymbalta, and Lidoderm patches with good relief of her complex regional pain syndrome. The patient has also had a spinal cord stimulator in the past. The disputed issue is for a repeat right sided lumbar sympathetic nerve block. The utilization review determination on 12/10/2013 had noncertified this request due to limited documentation of functional improvement and pain relief following previous sympathetic blocks.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT LUMBAR SYMPATHETIC NERVE BLOCK: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Sympathetic Blocks Section Page(s): 103-104.

Decision rationale: The Chronic Pain Medical Treatment Guidelines on pages 103-104 specify the following regarding regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, & lumbar sympathetic block)". "Recommendations are generally limited to diagnosis and therapy for CRPS. See CRPS, sympathetic and epidural blocks for specific recommendations for treatment. Also see CRPS, diagnostic criteria; CRPS, medications; & CRPS. Stellate ganglion block (SGB) (Cervicothoracic sympathetic block): There is limited evidence to support this procedure, with most studies reported being case studies. The one prospective double-blind study (of CRPS) was limited to 4 subjects. Anatomy: Sympathetic flow to the head, neck and most of the upper extremities is derived from the upper five to seven thoracic spinal segments. The stellate ganglion is formed by a fusion of the inferior and first thoracic sympathetic ganglia in 80% of patients. In the other 20%, the first thoracic ganglion is labeled the stellate ganglion. The upper extremity may also be innervated by branches for Kuntz's nerves, which may explain inadequate relief of sympathetic related pain. Proposed Indications: This block is proposed for the diagnosis and treatment of sympathetic pain involving the face, head, neck, and upper extremities. Pain: CRPS; Herpes Zoster and post-herpetic neuralgia; Frostbite. Circulatory insufficiency: Traumatic/embolic occlusion; Post-reimplantation; Post-embolic vasospasm; Raynaud's disease; Vasculitis; Scleroderma. Testing for an adequate block: Adequacy of a sympathetic block should be recorded. A Horner's sign (ipsilateral ptosis, miosis, anhydrosis conjunctival engorgement, and warmth of the face) indicates a sympathetic block of the head and face. It does not indicate a sympathetic block of the upper extremity. The latter can be measured by surface temperature difference (an increase in temperature on the side of the block). Somatic block of the arm should also be ruled out (the incidence of brachial plexus nerve block is ~ 10%). Complete sympathetic blockade can be measured with the addition of tests of abolition of sweating and of the sympathogalvanic response. Documentation of motor and/or sensory block should occur. Complications: Incidental recurrent laryngeal nerve block or superior laryngeal nerve block, resulting in hoarseness and subjective shortness of breathe; Brachial plexus block; Intravascular injection; Intrathecal, subdural or epidural injection; Puncture of the pleura with pneumothorax; Bleeding and hematoma. There appears to be a positive correlation between efficacy and how soon therapy is initiated (as studied in patients with CRPS of the hand). Duration of symptoms greater than 16 weeks before the initial SGB and/or a decrease in skin perfusion of 22% between the normal and affected hands adversely affected the efficacy of SGB therapy. (Ackerman, 2006) (Sayson, 2004) (Grabow, 2005) (Colorado, 2006) (Price, 1998) (Day, 2008) (Nader, 2005) See also Stellate ganglion block. Lumbar Sympathetic Blocks: There is limited evidence to support this procedure, with most studies reported being case studies. Anatomy: Consists of several ganglia between the L1 and L5 vertebra. Proposed Indications: Circulatory insufficiency of the leg: (Arteriosclerotic disease; Claudication: Rest pain; Ischemic ulcers; Diabetic gangrene; Pain following arterial embolus). Pain: Herpes Zoster; Post-herpetic neuralgia; Frostbite; CRPS; Phantom pain. These blocks can be used diagnostically and therapeutically. Adjunct therapy: sympathetic therapy should be accompanied by aggressive physical therapy to optimize success. Complications: Back pain; Hematuria; Somatic block; 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 blockade can be measured with the addition of tests of abolition of sweating and of the sympathogalvanic response. (Day, 2008) (Sayson, 2004) (Nader, 2005)". In the case of this injured worker, there has been documentation of previous lumbar sympathetic blocks performed in March 2012. The patient has "responded well to lumbar sympathetic blocks in the past." While other interventional pain injections require documentation of a certain

percentage decrease in pain score for a certain period of time, the guidelines do not have these specifications for repeat sympathetic blocks. In fact the guidelines are notably silent with regard to criteria for repeat sympathetic blocks. In general, sympathetic blockade tend to be of a transient nature and can temporarily reduce pain in patient with complex regional pain syndrome. As it is evident that this injured worker has tried most other approaches to this pain, including functional restoration, spinal cord stimulator, neuropathic pain medications, and opiates, it is reasonable in this clinical context to repeat lumbar sympathetic blocks. This request is recommended for certification.