

<b>Case Number:</b>	CM13-0071354		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	01/23/2013
<b>Decision Date:</b>	04/21/2014	<b>UR Denial Date:</b>	12/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/27/2013

### 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 Family Practice, has a subspecialty in Preventative 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 49 year old male claimant sustained a work injury on 1/23/13 involving the left hand, near amputation of the index finger and open fracture with radial neurovascular bundle laceration. He underwent repair of the laceration, reduction of the proximal phalanx and neurolysis of the radial digital nerve. Due to the injury he developed reflex sympathetic dystrophy, He had occupational therapy and oral analgesics but continued to have pain in the finger. Due to complex regional pain a stellate ganglion block was performed on 9/3/13. An exam report on 11/15/13 noted that he continued to use oral and topical analgesics and continued to have index finger pain. An authorization was requested for another ganglion block.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Left stellate ganglion block under fluoroscopic guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Regional sympathetic Blocks Page(s): 103.

**Decision rationale:** 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. The lack of strong evidence, along with no significant improvement of symptoms after the procedure in September, does not necessitate additional stellate ganglion blocks.