

Case Number:	CM14-0015607		
Date Assigned:	04/09/2014	Date of Injury:	02/17/1997
Decision Date:	05/28/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/07/2014

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 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:

According to the records made available for review, the patient is a 63-year-old male with a 2/17/97 date of injury, and status post left shoulder arthroscopy 10/15/12 and status post revision distal clavicle resection 7/29/13. There is documentation of subjective findings of symptomatic left shoulder pain; continues to note benefit from cervical epidural steroid injection performed 11/7/13 with 60% improvement, decreased neck pain as well as numbness and tingling in distal left upper extremity; severe pain in the left shoulder with burning and electrical pain in the shoulder and upper arm, some numbness and tingling. Objective findings of myofascial tenderness over the left greater than right paraspinal musculature, 1+ muscle spasm, tenderness at the right shoulder anterior aspect as well as over the subacromial bursa, restricted range of motion by pain, left shoulder allodynia over the deltoid region, limited range of motion, weakness with the left deltoid 4/5, hypoesthesia in the left C7 dermatome. Current diagnoses include mild acute C5-6 radiculopathy on the left per EDS 11/4/10, complex regional pain syndrome bilateral upper extremities. Treatment to date includes medications, post-op shoulder PT, CESIs, and stellate ganglion blocks (most recent 3/7/13 with reported 30% improvement; previous stellate ganglion blocks provided 70-80% improvement).

IMR ISSUES, DECISIONS AND RATIONALES

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

REPEAT LEFT STELLATE GANGLION BLOCK UNDER FLUOROSCOPY
GUIDANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Cervical and Thoracic Spine Disorders

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRPS, Sympathetic and Epidural Block Page(s): 39-40.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of continued improvement, as criteria necessary to support the medical necessity of additional stellate ganglion blocks. The Official Disability Guidelines (ODG) identifies documentation of evidence of increased range of motion, pain and medication use reduction and increased tolerance of activity and touch (decreased allodynia) in physical therapy/occupational therapy, as well as evidence that physical or occupational therapy is incorporated with the duration of symptom relief of the block as criteria necessary to support the medical necessity of additional stellate ganglion blocks. Within the medical information available for review, there is documentation of diagnosis of complex regional pain syndrome bilateral upper extremities. In addition, there is documentation of previous stellate ganglion blocks, with most recent block done 3/7/13 with reported 30% improvement. However, there is no documentation of increased range of motion, pain and medication use reduction, increased tolerance of activity and touch (decreased allodynia) in physical therapy/occupational therapy, and evidence that physical or occupational therapy is being incorporated with the duration of symptom relief of the block. The request for repeat left stellate ganglion block under fluoroscopy guidance is not medically necessary and appropriate.