

<b>Case Number:</b>	CM14-0016019		
<b>Date Assigned:</b>	06/04/2014	<b>Date of Injury:</b>	05/28/2012
<b>Decision Date:</b>	07/14/2014	<b>UR Denial Date:</b>	01/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	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, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 35-year-old male who reported an injury on 05/28/2012. The mechanism of injury was reported to be a fall. Per the orthopedic progress note dated 12/16/2013, the injured worker reported pain, stiffness, numbness, and burning to the left arm. On physical examination, the injured worker was reported to hold the elbow flexed at 90 degrees and the wrist flexed at 30 degrees. The range of motion for the left elbow was reported to be extension -90 degrees, flexion 110 degrees. Range of motion for the left wrist was noted as extension at 20 degrees, and flexion was 30 degrees. Sensation was noted to be intact. Per the progress note from pain management dated 05/14/2014, the injured worker continued to report left upper extremity pain, and weakness over the left elbow and left wrist. The diagnosis for the injured worker was reported to be reflex sympathetic dystrophy of the upper limb. Previous treatments for the injured worker included surgery to the left wrist and elbow, a TENS unit, physical therapy, and pain injections. The Request for Authorization for stellate ganglion blocks, gabapentin, and Nortriptyline was submitted 01/14/2014. The provider's rationale for the request for the ganglion blocks, gabapentin, and Nortriptyline was reported to be for pain control for the complex regional pain syndrome (CRPS).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**THREE (3) STELLATE GANGLION BLOCKS UNDER FLUOROSCOPIC GUIDANCE:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CERVICOTHORACIC SYMPATHETIC BLOCK. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), PAIN (CHRONIC), CRPS, SYMPATHETIC BLOCKS (THERAPEUTIC).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines REGIONAL SYMPATHETIC BLOCKS (STELLATE GANGLION BLOCK, THORACIC SYMPATHETIC BLOCK, & LUMBAR SYMPATHETIC BLOCK) Page(s): 103-104.

**Decision rationale:** The Chronic Pain Guidelines indicate that stellate ganglion blocks are recommended for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. Stellate ganglion blocks, also known as cervicothoracic sympathetic blocks, have limited evidence to support the procedure, with most studies reported to be case studies. Indications include for the diagnosis and treatment of sympathetic pain involving the face, head, neck and upper extremities. The blocks are recommended for pain associated with complex regional pain syndrome (CRPS), herpes zoster, and postherpetic neuralgia, as well as frostbite. Repeated blocks are only recommended if continued improvement is observed. The documentation provided noted the injured worker had previously been approved for two (2) stellate ganglion blocks; however, there is a lack of documentation regarding the use of those blocks. There is a lack of documentation regarding the outcomes of physical therapy and a home exercise program. The documentation provided notes that three (3) blocks have been administered; however, there is a lack of clinical documentation regarding the outcome of those blocks including objective functional improvement, significant pain relief, and decreased medication usage. Therefore, the request is not medically necessary.

**ONE (1) PRESCRIPTION OF GABAPENTIN 300MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTIEPILEPSY DRUGS (AEDs); GABAPENTIN.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTIEPILEPSY DRUGS (AEDS) Page(s): 17-18.

**Decision rationale:** The Chronic Pain Guidelines indicate that gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered as a first line treatment for neuropathic pain. A good response to the use of anti-epileptic drugs has been defined as a 50% reduction in pain and a moderate response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients, and a lack of response may be the trigger for a change to a different first line agent or combination therapy of treatment when a single drug agent fails. After initiation of treatment, there should be documentation of pain relief and improvement in function, as well as documentation of side effects incurred with use. The continued use of anti-epileptic drugs depends on improved outcomes versus tolerability of adverse effects. Gabapentin has been recommended for the treatment of complex regional pain syndrome (CRPS). There is a lack of documentation regarding the utilization of this medication including a significant decrease in pain and any side effects. In addition, there is a lack of documentation regarding an improvement

in function. The request does not specify the quantity requested or the frequency information for the medication. Therefore, the request is not medically necessary.

**ONE (1) PRESCRIPTION OF NORTRIPTYLINE 10MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation AMITRIPTYLINE.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS FOR CHRONIC PAIN; TRICYCLICS Page(s): 13-16, 122.

**Decision rationale:** The Chronic Pain Guidelines indicate that tricyclics are recommended and generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medications, sleep quality and duration, and psychological assessment. Tricyclic antidepressants are considered a first line treatment for neuropathic pain. Indications in controlled trials have shown effectiveness in treating central post-stroke pain, postherpetic neuralgia, painful diabetic and non-diabetic polyneuropathy, and post-mastectomy pain. Negative results were found for spinal cord pain and phantom limb pain. There is a lack of documentation regarding the efficacy of this medication, including a decrease in pain or increase in functionality. There is a lack of documentation regarding a decrease in the utilization of other analgesic medications. There is a lack of documentation regarding sleep patterns and quality as well as documentation of a psychological assessment. In addition, the request fails to include a quantity requested or the frequency information for the medication. Therefore, the request is not medically necessary.