

Case Number:	CM14-0048822		
Date Assigned:	06/25/2014	Date of Injury:	04/26/2002
Decision Date:	07/25/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	03/27/2014

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 Occupational 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:

A note by [REDACTED] dated 01/08/14 states she had the interlaminar epidural injection at right T5-6 with 80% decrease in right chest wall neuropathic pain and allodynia but she noted partial return of the pain. She had increased allodynia in the right distal upper extremity and decreased sensation to touch in the right fourth and fifth fingers. Color changes were present between the hands. She had slight shiny skin changes on the dorsum of the right fingers. There were no temperature, swelling, or nail changes present. She had received psychological therapy. She saw [REDACTED] on 01/09/14 and was 100% disabled and had multiple diagnoses including complex regional pain syndrome involving the right upper extremity, status post superior labrum anterior and posterior repair of the right shoulder in January 2005, postop adhesive capsulitis with capsular release in May 2005, posterior right capsular release in July 2007, right shoulder dislocation reduction in July 2007, right cervicobrachial neuritis, right ulnar neuropathy with intrinsic muscle atrophy, cervical disc disease at several levels, right wrist TFCC tear, right elbow spurring on magnetic resonance imaging (MRI) in May 2013, right hip pain with iliopsoas and iliotibial band subluxation, and other medical problems. She has ongoing pain. Physical examination reveals tenderness at the right shoulder. There was minimal overhead activity and range of motion in the right shoulder which was nonfunctional. The right hand had fine motor control for digits 2 and 3 and was extremely weak in digits 4 and 5 due to ulnar neuropathy. Allodynia, hyperpathia, and sensitivity to touch were still present and she was still very guarded. She has chronic pain in the right upper extremity, biceps tendon and right medial pectoralis muscle. She also has neuropathic pain affecting the right upper extremity. She complains of significant pain radiating down the posterior cervical spine and had tenderness at the biceps tendon and pectoralis muscle on the right side. She has minimal overhead activity and minimal range of motion of the right shoulder, which is nonfunctional. She has extremely weak fourth and fifth digits due to ulnar neuropathy. Allodynia, hyperpathia, and sensitivity to touch are still present. She was still quite guarded and was 100% disabled. She underwent a right bicipital

tendon steroid injection on 02/25/14 and on 03/11/14 reported 60% decrease in her right anterior shoulder pain. She had a right stellate ganglion block on 12/12/13 and noted 60% decrease in the right upper extremity neuropathic pain but the pain had returned. She has been taking several medications. Cervical spine had myospasm and tenderness. Right shoulder had subacromial, subdeltoid, and coracoid bursa tenderness and impingement sign was noted. She had allodynia over the right anterior shoulder. Her strength was difficult to test due to pain and there was weakness of right fourth and fifth finger flexion. Color changes were present. She has slightly shiny skin changes on the dorsum of the right fingers. A series of 3 right stellate ganglion blocks were recommended. The provider indicated in an appeal letter that during the period of decreased right upper extremity neuropathic pain after the stellate ganglion block in December 2013, from 12/12/13-03/01/14, the claimant noted 60% decrease in neuropathic pain and allodynia allowing increased tolerance to touch, increased right shoulder range of motion, and decreased analgesic medication usage. She was not currently in a functional restoration program due to her past inability to effectively participate in such a program due to her residual pain and allodynia. She was currently taking Cymbalta, Valium, Soma, Nucynta, Dilaudid, and tramadol. She has been diagnosed with complex regional pain syndrome of the right upper extremity and right shoulder status post injury and multiple surgeries. She also has adhesive capsulitis of the right shoulder, right ulnar neuropathy, status post surgery for a superior labral lesion and subsequent surgery for adhesive capsulitis. She reportedly had gains in range of motion and decreased medication usage and increased tolerance to functional activities and touch after the initial injection. She also had a right bicipital tendon sheath injection on 02/25/14. She is also status post thoracic epidural steroid injections in October 2013. ██████ appealed the repeat thoracic interlaminar epidural injection for thoracic sympathetic blockade.

IMR ISSUES, DECISIONS AND RATIONALES

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

SERIES OF THREE RIGHT STELLATE GANGLION BLOCK UNDER FLUOROSCOPIC GUIDANCE WITH IV SEDATION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page 71 Page(s): page 71.

Decision rationale: The history and documentation do not objectively support the request for a series of three right stellate ganglion blocks under fluoroscopic guidance with IV sedation. The California Medical Treatment Utilization Schedule (MTUS) state stellate ganglion block may be "recommended, for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. Detailed information about stellate ganglion blocks, thoracic sympathetic blocks, and lumbar sympathetic blocks is found in Regional sympathetic blocks. Use of sympathetic blocks include diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. It should be noted that sympathetic blocks are not specific for CRPS. Repeated blocks are only recommended if continued improvement is observed. Systematic reviews reveal a paucity of published evidence supporting the use of local anesthetic sympathetic blocks for the treatment of CRPS and usefulness remains controversial. Less than 1/3 of patients with CRPS are likely to respond to sympathetic blockade. No controlled trials have shown any significant benefit from sympathetic blockade. (Varrassi, 2006) (Cepeda, 2005)

(Hartrick, 2004) (Grabow, 2005) (Cepeda, 2002) (Forouzanfar, 2002) (Sharma, 2006)
Predictors of poor response: Long duration of symptoms prior to intervention; Elevated anxiety levels; poor coping skills; Litigation. (Hartrick, 2004) (Nelson, 2006). In this case, the claimant had a good response to this type of injection in 12/2013 but the duration of the response is not stated. If she received 60% pain relief, it is not clear why she remained unable to continue with an active rehab program to try to maintain any benefit. These injections are not supported as stand-alone treatment but are only recommended in conjunction with active rehabilitative efforts. She also has other medical conditions involving her right shoulder and upper extremity which are likely to be keeping her from being able to do a rehab program. Her history of psychological distress and the duration of her chronic pain and inability to exercise increase the chances of a less than optimal response. Also, repeat injections of this type are not supported unless ongoing improvement can be documented.