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| Case Number: | CM13-0026743 | | |
| Date Assigned: | 11/22/2013 | Date of Injury: | 10/11/2010 |
| Decision Date: | 02/28/2015 | UR Denial Date: | 09/13/2013 |
| Priority: | Standard | Application Received: | 09/19/2013 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Indiana, New York
Certification(s)/Specialty: Internal Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 51 year old male with a work injury dated 10/11/2010. He was working on a sloped surface and felt something pop and give in the foot. The injured worker (IW) reports the pain is of severe intensity without treatment on a regular basis. The pain is described as aching and stabbing and is worse with ambulation. The pain is partially relieved by the use of analgesic medications and various types of injection therapy. The IW had tried conservative options such as simple analgesics and physical therapy which were not helpful and did not last in regards to pain reduction or functional improvement. The IW's pain and suffering was currently affecting his ability to participate in activities of daily living. Physical exam revealed a mildly antalgic gait. Palpation of the area revealed tenderness in the region concordant with the patient's described area of pain. Muscle strength was reduced in the plantar flexor muscles. The IW was not able to toe and heel walk. Diagnoses were: Pain in limb, reflex sympathetic dystrophy of lower limb, encounter for long term use of other medication and sleep disturbance not otherwise specified. A manual muscle testing procedure was performed in the office utilizing objective strength assessment of the lower extremities during the visit. Dynamic muscle testing of the lower extremities revealed that during a maximal flexion contraction of the lower extremity the patient was able to generate a 3/5 R and 5/5 L relative amount of applied force against a fixed object. The test was repeated with confirmation of visible effort and both results were within 10% of one another. The provider requested the following:- Sudo-motor testing to provide objective evidence of CRPS- Trial of lumbar sympathetic plexus blocks to see if this alleviates his CRPS- Possible popliteal nerve blocks if sympathetic blocks were not

useful. On September 13, 2013 utilization review issued the following decision regarding the above requested testing stating: The claimant has findings on exam and complaints that are consistent with this diagnosis and a trial of 1 lumbar sympathetic block for diagnostic purposes is indicated at this time. The need for sudo motor testing and popliteal block in addition to the sympathetic block is not established as a medical necessity without review of the results from the sympathetic block. If the sympathetic block response is positive then the sudo- motor testing and popliteal block is unnecessary. Recommend partial certification of 1 lumbar sympathetic block and non-certification of the popliteal nerve block and sudo motor testing. The following guidelines were cited:- Sudo-motor testing: ODG-TWC Pain Procedure Summary last updated 06/07/2013- Lumbar sympathetic blocks - MTUS, Chronic Pain Medical Treatment Guidelines- Popliteal block - Waldman: Atlas of Interventional Pain Management 2nd edition Chapter 101- Sciatic Nerve BlockThe request was appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

SUDOMOTOR TESTING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), PAIN

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation
http://www.aetna.com/cpb/medical/data/400_499/0485.html

Decision rationale: Pursuant Aetna Clinical Policy Bulletin: Autonomic Testing/Sudomotor Testing, Sudomotor Testing is not medically necessary. Aetna clinical policy bulletin considers autonomic testing such as quantitative sudomotor axon reflex test, silastic sweat imprint, and thermoregulatory sweat test medically necessary for use as a diagnostic tool for any of the following conditions/disorders: amyloid neuropathy; diabetic autonomic neuropathy; distal small fiber neuropathy; idiopathic neuropathy; multiple system atrophy; pure autonomic failure; reflex sympathetic dystrophy or causalgia (sympathetically mediated pain) and Sjogren's syndrome. Aetna considers autonomic testing experimental and investigational for all other indications. In this case, the injured worker's working diagnoses are pain in limb; reflex sympathetic dystrophy of lower limb; encounter for long-term use of other medications; and sleep disturbances, not otherwise specified. There was a single progress note in the medical record dated August 30, 2013. The subjective complaints indicate the injured worker has chronic foot pain for several years status post industrial injury. The pain is severe and aching. Physical therapy was not helpful. On physical examination the treating physician indicates there are no significant varicosities or vascular abnormalities. Muscle strength is reduced in the plantar flexor muscles. The injured worker is not able to heel - toe walk. There was no discussion/documentation of the work up to date or differential diagnosis with the resulting reflex sympathetic dystrophy. Progress note did not indicate which limb was to be tested. The documentation contains a conclusion regarding the diagnosis but there is no evidence of work up to date other than

physical therapy. The documentation in the medical record indicates the treating physician is ordering sudomotor testing to provide objective evidence CRPS. Consequently, absent clinical documentation to support the diagnosis of CRPS and the anatomical region to be tested, Sudomotor testing is not medically necessary.

TRIAL OF LUMBAR SYMPATHETIC BLOCKS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain section,. CRPS, sympathetic blocks

Decision rationale: Pursuant to the Official Disability Guidelines, trial lumbar sympathetic plexus block (to see if this alleviates CRPS) is not medically necessary. Less than one third of patients with C RPS are likely to respond to sympathetic blocks. There are no signs or symptoms to predict success. The use of sympathetic blocks for diagnostic purposes in CRPS one is based on previous hypotheses concerning involvement of sympathetic nervous system as a pathophysiologic cause of the disease. Recommendations for an adequate CRPS evaluation include: evidence the Hardin criteria have been evaluated for and fulfilled; evidence all other diagnoses have been ruled out. A diagnosis of CRPS should not be accepted without a documented and complete differential diagnostic process completed as part of the record; there should be evidence the sympathetic block fulfills criteria for success including skin temperature after the block shows sustained increase (greater than or equal to 1.5 and or an increase in temperature waves and 34) without evidence of thermal or tactile sensory block. The use of sedation with the block can influence results. In this case, the injured worker's working diagnoses are pain and limb; Reflex sympathetic dystrophy of lower limb; encounter for long-term use of other medications; and sleep disturbances, not otherwise specified. There was a single progress note in the medical record dated August 30, 2013. The subjective complaints indicate the injured worker has chronic foot pain for several years status post industrial injury. The pain is severe and aching. Physical therapy was not helpful. On physical examination the treating physician indicates there are no significant varicosities or vascular abnormalities. Muscle strength is reduced in the plantar flexor muscles. The injured worker is not able to heel - toe walk. There was no discussion of the work up to date or differential diagnosis with the resulting reflex sympathetic dystrophy. Progress note did not indicate which limb was to be tested. The documentation contains a conclusion regarding the diagnosis but there is no evidence of work up to date other than physical therapy. The medical record does not contain evidence of Hardin criteria and evidence other diagnoses have been ruled out. The guidelines indicate a diagnosis of CRPS should not be accepted without a documented and complete differential diagnostic process completed as part of the record. It was not in the record. Consequently, absent the required clinical documentation establishing a diagnosis of CRPS, trial lumbar sympathetic plexus block (to see if this alleviates CRPS) is not medically necessary.

POSSIBLE POPLITEAL NERVE BLOCKS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation WALDMAN: ATLAS OF INTERVENTIONAL PAIN MANAGEMENT, 2ND ED., CHAPTER 101-SCIATIC NERVE BLOCK

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://emedicine.medscape.com/article/2000653-overview>

Decision rationale: Pursuant to Medscape (peer-reviewed evidence-based guideline), popliteal or block is not medically necessary. A popliteal nerve block is indicated for pain control perioperative or postoperatively below the patella, the distal two thirds of the lower extremity especially for ankle or foot or Achilles tendon. It provides great analgesia. It does miss the medial aspect of the leg which is innervated by the saphenous nerve, a cutaneous extension of the femoral nerve. In this case, the injured worker's working diagnoses are pain and limb; Reflex sympathetic dystrophy of lower limb; encounter for long-term use of other medications; and sleep disturbances, not otherwise specified. There was a single progress note in the medical record dated August 30, 2013. The treating physician documented medical record popliteal nerve block would be performed if the sympathetic block was not successful. The sympathetic nerve block was not medically necessary and consequently, the popliteal nerve block is not medically necessary. The documentation, as noted above, is incomplete with regards the workup, ongoing signs and symptoms of CRPS as it relates to the injured worker. Consequently, because the sympathetic block was not medically necessary, the popliteal or block is not medically necessary.