

<b>Case Number:</b>	CM14-0195372		
<b>Date Assigned:</b>	12/03/2014	<b>Date of Injury:</b>	08/08/2009
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2014

### 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 Family Practice and is licensed to practice in Ohio. 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 65-year-old female with a date of injury of August 8, 2009. She lost her balance and a rolling cart fell on her. She has had chronic low back pain radiating to the lower extremities with numbness and tingling, chronic bilateral knee pain, left hand and wrist pain, and neck pain radiating to the right upper extremity associated with burning to the right arm, shoulder, and chest wall. Diagnostic imaging has revealed evidence of cervical degenerative disc disease and multilevel neuroforaminal stenosis characterized as severe on the right side at C3-C4 and C4-C5. The physical exam reveals diminished cervical range of motion with a positive Spurling's maneuver on the left and a positive cervical distraction test. There is diminished sensation in the C5 and C6 dermatome region on the left and the C7 dermatome region on the right. Bilateral thenar eminence atrophy is noted. She has been noted to have intact sensation to light touch and normal motor strength in the upper extremities. The diagnoses include right thoracic outlet syndrome, cervical spine sprain/strain, cervical degenerative disc disease, multilevel cervical foraminal stenosis, and lumbar radiculopathy. She also has a diagnosis of bilateral carpal tunnel syndrome. She had a lumbar fusion surgery at L4-L5 in 2010. The right-sided stellate ganglion block was performed on August 29, 2014. She reported a 50% improvement in pain or 4 days and the pain level relief was 25% at 3 weeks. At issue is a request for a series of stellate ganglion blocks, once every 2 weeks, for a series of 4 total injections.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Stellate ganglion block one every two weeks times 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 103. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), CRPS, pathophysiology (clinical presentation & diagnostic criteria and CRPS, sympathetic blocks therapeutic

**Decision rationale:** Recommendations (based on consensus guidelines) for use of sympathetic blocks (diagnostic block recommendations are included here, as well as in Complex regional pain syndrome (CRPS), diagnostic tests): (1) There should be evidence that all other diagnoses have been ruled out before consideration of use. (2) There should be evidence that the Budapest (Harden) criteria have been evaluated for and fulfilled for chronic regional pain syndrome. (3) If a sympathetic block is utilized for diagnosis, there should be evidence that this block fulfills criteria for success including that skin temperature after the block shows sustained increase ( 1.5 C and/or an increase in temperature to > 34 C) without evidence of thermal or tactile sensory block. Documentation of motor and/or sensory block should occur. This is particularly important in the diagnostic phase to avoid overestimation of the sympathetic component of pain. A Horner's sign should be documented for upper extremity blocks. The use of sedation with the block can influence results, and this should be documented if utilized. The Budapest (Harden) Criteria represent a revision of the above IASP Criteria. There are two versions of these proposed diagnostic criteria. A diagnostic version was developed to maximize sensitivity (identify true positive cases) with adequate specificity (i.e. avoiding a false positive diagnosis). A research version was developed to more equally balance sensitivity and specificity. The diagnostic criteria are the following: (1) Continuing pain, which is disproportionate to any inciting event; (2) Must report at least one symptom in three of the four following categories: (a) Sensory: Reports of hyperesthesia and/or allodynia; (b) Vasomotor: Reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry; (c) Sudomotor/Edema: Reports of edema and/or sweating changes and/or sweating asymmetry; (d) Motor/Trophic: Reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); (3) Must display at least one sign at time of evaluation in two or more of the following categories: (a) Sensory: Evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or temperature sensation and/or deep somatic pressure and/or joint movement); (b) Vasomotor: Evidence of temperature asymmetry (>1C) and/or skin color changes and/or asymmetry; (c) Sudomotor/Edema: Evidence of edema and/or sweating changes and/or sweating asymmetry; (d) Motor/Trophic: Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); (4) There is no other diagnosis that better explains the signs and symptoms. This diagnostic version produces a sensitivity of 85% and specificity of 69%. The research version requires reporting of at least one symptom in each of the four categories (vs. in three of the four in the diagnostic version). This provides a sensitivity of 70% and specificity of 96%. In this instance, there was insufficient documentation of fulfillment of the Budapest criteria for diagnosis of chronic regional pain syndrome. Sensation was noted to be intact to light touch and the upper motor groups were said to be normal. There were no submitted reports of edema or abnormal sweating of the right upper extremity or nail or hair dystrophy. There was no submitted evidence of temperature asymmetry

before the injection. No muscular weakness, tremor, or dystonia was noted. A review of the operative report from the diagnostic stellate ganglion block does not indicate evidence of a temperature increase for the right upper extremity and a Horner's sign was not documented following the block. Horner's syndrome is caused by sympathetic blockade and produces the following features on the ipsilateral side of the face: drooping of the eyelid (ptosis), constriction of the pupil (meiosis), decreased sweating of the face on the same side (anhidrosis), redness of the conjunctiva of the eye, impression of an apparently sunken eyeball (enophthalmos). This may also lead to increased amplitude of accommodation, paradoxical contralateral eyelid retraction, transient decrease in intraocular pressure and changes in tear viscosity. Although it may be considered a complication, the presence of Horner's syndrome is a confirmatory sign of successful stellate ganglion blockade. Because the criteria for CRPS was not seemingly satisfied (or submitted for review) prior to the diagnostic stellate ganglion block and because the stigmata of a successful block were not present afterwards (again, or submitted for review), stellate ganglion blocks one every two weeks for a total of 4 injections are not medically necessary per the referenced guidelines.