

Case Number:	CM14-0205457		
Date Assigned:	12/17/2014	Date of Injury:	01/21/2010
Decision Date:	02/12/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	12/08/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 44 year old employee with date of injury of 1/21/10. Medical records indicate the patient is undergoing treatment for s/p lumbar fusion surgery; previous history of left leg and foot CRPS with some residual intermittent symptomology; left lower extremity motor and sensory radiculopathy with mild foot drop. Subjective complaints include neuropathic syndrome in the left foot and ankle, characterized as severe, that came on after lumbar surgery. Her Norco has been reduced to four times a day and she is weaning off other medications. She wears an AFO brace. She has episodes of neuropathic pain when she is on her feet, lifting or bending a lot. She will get pain followed by small skin bumps that are discolored (purplish, red) followed by soft tissue swelling, then hypersensitivity and pain. She describes her pain as "burning" which causes difficulties working and her acts of daily living. Her symptoms reduced "significantly" after sympathetic ganglion blocks (12/14/12) were performed. Her pain is currently 2-3/10 with medications and 7-8/10 without. Objective findings include continued foot drop that involves her left ankle and leg. Her gait is antalgic and she has episodes of falling. She has difficulty with heel-toe walk on the left. She has tenderness in the low back, particularly in the piriformis compartment and sciatic notch, greater on the left than right. She has decreased sensory in the left posterolateral thigh to the top of her foot to the first metatarsal and toe. Her deep tendon reflexes are symmetrical in the knees and ankles bilaterally and she has a negative straight leg bilaterally. Her left foot is colder to the touch than the right. Treatment has consisted of sympathetic ganglion blocks (12/14/12); Norco; massage therapy and physical therapy. The utilization review determination was rendered on 11/19/14 recommending non-certification of Repeat left L2 selective sympathetic ganglion block.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat left L2 selective sympathetic ganglion block: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regional sympathetic blocks.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regional sympathetic blocks Page(s): 103-104. Decision based on Non-MTUS Citation Official Disability Guidelines Pain, CRPS, sympathetic blocks (therapeutic)

Decision rationale: MTUS states "Stellate ganglion block (SGB) (Cervicothoracic sympathetic block): There is limited evidence to support this procedure, with most studies reported being case studies. The one prospective double-blind study (of CRPS) was limited to 4 subjects..... Proposed Indications: This block is proposed for the diagnosis and treatment of sympathetic pain involving the face, head, neck, and upper extremities. Pain: CRPS; Herpes Zoster and post-herpetic neuralgia; Frostbite. Circulatory insufficiency: Traumatic/embolic occlusion; Post-reimplantation; Postembolic vasospasm; Raynaud's disease; Vasculitis; Scleroderma." ODG States "Recommendations (based on consensus guidelines) for use of sympathetic blocks (diagnostic block recommendations are included here, as well as in 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. (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. (Krumova, 2011) (Schurmann, 2001)(4) Therapeutic use of sympathetic blocks is only recommended in cases that have positive response to diagnostic blocks and diagnostic criteria are fulfilled (See #1-3). These blocks are only recommended if there is evidence of lack of response to conservative treatment including pharmacologic therapy and physical rehabilitation.(5) In the initial therapeutic phase, maximum sustained relief is generally obtained after 3 to 6 blocks. These blocks are generally given in fairly quick succession in the first two weeks of treatment with tapering to once a week. Continuing treatment longer than 2 to 3 weeks is unusual. (6) In the therapeutic phase repeat blocks should only be undertaken if there is evidence of increased range of motion, pain and medication use reduction, and increased tolerance of activity and touch (decreased allodynia) is documented to permit participation in physical therapy/ occupational therapy. Sympathetic blocks are not a stand-alone treatment.(7) There should be evidence that physical or occupational therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase.(8) In acute exacerbations of patients who have documented evidence of sympathetically mediated pain (see #1-3), 1 to 3 blocks may be required for treatment.(9) A formal test of the therapeutic blocks should be documented (preferably using skin temperature). The patient has a previous stellate ganglion block on 12/14/12 and the patient is noted to have gotten significant relief. However, the treating physician did not document

decreased medication use, percentage of a decrease in pain, increased functionality and continued participation in some form of physical therapy/ occupational therapy. As such, the request for Repeat left L2 selective sympathetic ganglion block is not medically necessary.