

Case Number:	CM15-0005846		
Date Assigned:	01/26/2015	Date of Injury:	09/18/2006
Decision Date:	03/17/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/12/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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:

The injured worker is a 64 year old claimant who sustained an industrial injury, reported on 9/18/2006, and has reported right hand and forearm pain. The diagnoses have included upper extremity reflex sympathetic dystrophy; shoulder joint pain; lower limb reflex sympathetic dystrophy; leg joint pain; ankle joint pain; pelvis joint pain; hand joint pain; forearm joint pain; and arm joint pain. Treatments to date have included consultations; diagnostic and imaging studies; 2 epidural steroid injections and lumbar sympathetic blocks; lumbar revision (11/12); physical therapy; psychiatric care; cane; and multiple medication management. The status classification for this injured worker (IW) was noted to be totally temporarily disabled. On 12/30/2014 Utilization Review (UR) non-certified, for medical necessity, the request, made on 12/22/2014, for left lumbar sympathetic block and an in-home health aid, the Medical Treatment Utilization Schedule, sympathetic blocks and homemaker services Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Lumbar Sympathetic Block: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Sympathetic and Epidural Blocks Page(s): 103-104.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, & lumbar sympha.

Decision rationale: According to MTUS guidelines, “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.” According to MTUS guidelines, lumbar sympathetic block Recommended as indicated below. Useful for diagnosis and treatment of pain of the pelvis and lower extremity secondary to CRPS-I and II. This block is commonly used for differential diagnosis and is the preferred treatment of sympathetic pain involving the lower extremity. For diagnostic testing, use three blocks over a 3-14 day period. For a positive response, pain relief should be 50% or greater for the duration of the local anesthetic and pain relief should be associated with functional improvement. Should be followed by intensive physical therapy.(Colorado, 2002)Based on the records submitted, there was no information submitted confirming the diagnosis of CRPS. Edema and skin abnormalities are missing from the provider report. Therefore, Left Lumbar Sympathetic Nerve Block is not medically necessary.

In-Home Aid: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regarding Home Health Services Page(s): 51.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: According to MTUS guidelines, home care assistance is “Recommended only for otherwise recommended medical treatment for patients who are home bound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. (CMS, 2004).” The patient does not fulfill the requirements mentioned above. There is no documentation that the patient recommended medical treatment requires home health aide. Therefore the request for Home care assistance is not medically necessary.