

<b>Case Number:</b>	CM15-0205374		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	10/24/2014
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	09/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2015

### 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: California, Oregon, Washington  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 46 year old woman sustained an industrial injury on 10-24-2014. Diagnoses include adhesive capsulitis, rotator cuff injury, cervicobrachial syndrome, chronic pain syndrome, and sprains and strains of shoulder. Treatment has included oral and topical medications and ganglion block. Physician notes dated 9-9-2015 show complaints of cervical spine pain and left shoulder pain. The physical examination shows apparent depression and fatigue, severe pain, with tearfulness. The left arm is in a sling with painful movement and swelling. Muscle strength is normal with the exception of left shoulder abduction and flexors are 3 out of 5. Recommendations include extension for prior authorized hand therapy desensitization, repeat stellate ganglion block on the left, continue use of sling, functional rehabilitation program evaluation, continue wearing isotoner on the left hand, and internal medicine consultation. Utilization Review denied requests for left stellate ganglion block and functional rehabilitation program evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left stellate ganglion block:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, & lumbar sympathetic block).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Complex Regional Pain Syndrome (CRPS), Stellate ganglion block.

**Decision rationale:** Per the CA MTUS/Chronic Pain Medical Treatment Guidelines, CPRS, Sympathetic and epidural blocks, page 39-40, repeated blocks are only recommended if continued improvement is observed. In this case the exam note from 9/9/15 demonstrates only partial and short term relief from the prior stellate ganglion block. Therefore the guidelines have not been met and determination is for non-certification. Therefore, the requested treatment is not medically necessary.

**Functional restoration program evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs).

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, Chronic Pain programs (functional restoration programs), pages 30-32, is recommended when patients have conditions that put them at risk for delayed recovery. In addition criteria includes "previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement." Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. In this case the submitted documentation does not indicate that baseline functional testing has been performed, exhaustive pharmacotherapy has been attempted, or that the claimant exhibits motivation to change and is willing to forgo secondary gains. Therefore, the guidelines for this request have not been met and the determination is for non-certification. Therefore, the requested treatment is not medically necessary.

