

Case Number:	CM15-0224097		
Date Assigned:	11/20/2015	Date of Injury:	05/15/1998
Decision Date:	12/30/2015	UR Denial Date:	10/29/2015
Priority:	Standard	Application Received:	11/13/2015

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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

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 28-year-old female, with a reported date of injury of 05-15-1998. The diagnoses include complex regional pain syndrome and brachial plexus neuropathy. The progress report dated 09-22-2015 is handwritten and somewhat illegible. The report indicates that the injured worker had good relief with right plexus block. The objective findings include weakness and numbness in the left hand. The injured worker has been instructed to return to modified work. The progress report dated 10-20-2015 is handwritten and somewhat illegible. The report indicates that the injured worker had 4 months of relief on the right with injection, but now needs a repeat on the right. The objective findings include weak hands and numb hands, right greater than left. The injured worker has been instructed to return to modified work. The diagnostic studies to date have not been included in the medical records provided. Treatments and evaluation to date have included a brachial plexus block and stellate ganglion block on 01-14-2015; a right stellate block, and right brachial plexus block and injection on 06-25-2015. The treating physician requested bilateral brachial plexus block with sedation. On 10-29-2015, Utilization Review (UR) non-certified the request for bilateral brachial plexus block with sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral brachial plexus block with sedation: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Complex Regional Pain Syndrome (CRPS), Intravenous regional sympathetic blocks (for RSD/CRPS, nerve blocks).

Decision rationale: Bilateral brachial plexus block with sedation is medically necessary. The patient did demonstrate four months of functional benefit and return to work following the previous block. Recommendations are generally limited to diagnosis and therapy for CRPS. See CRPS, sympathetic and epidural blocks for specific recommendations for treatment. Also see CRPS, diagnostic criteria; CRPS, medications; & CRPS. 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. Anatomy: Sympathetic flow to the head, neck and most of the upper extremities is derived from the upper five to seven thoracic spinal segments. The stellate ganglion is formed by a fusion of the inferior and first thoracic sympathetic ganglia in 80% of patients. In the other 20%, the first thoracic ganglion is labeled the stellate ganglion. The upper extremity may also be innervated by branches for Kuntz's nerves, which may explain inadequate relief of sympathetic related pain. 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; Post-embolic vasospasm; Raynaud's disease; Vasculitis; Scleroderma, Testing for an adequate block: Adequacy of a sympathetic block should be recorded. A Horner's sign (ipsilateral ptosis, miosis, anhydrosis conjunctival engorgement, and warmth of the face) indicates a sympathetic block of the head and face. It does not indicate a sympathetic block of the upper extremity. The latter can be measured by surface temperature difference (an increase in temperature on the side of the block). Somatic block of the arm should also be ruled out (the incidence of brachial plexus nerve block is ~ 10%). Complete sympathetic blockade can be measured with the addition of tests of abolition of sweating and of the sympathogalvanic response. Documentation of motor and/or sensory block should occur. Complications: Incidental recurrent laryngeal nerve block or superior laryngeal nerve block, resulting in hoarseness and subjective shortness of breath; Brachial plexus block; Intravascular injection; Intrathecal, subdural or epidural injection; Puncture of the pleura with pneumothorax; Bleeding and hematoma. There appears to be a positive correlation between efficacy and how soon therapy is initiated (as studied in patients with CRPS of the hand). Duration of symptoms greater than 16 weeks before the initial SGB and/or a decrease in skin perfusion of 22% between the normal and affected hands adversely affected the efficacy of SGB therapy. (Ackerman, 2006) (Sayson, 2004) (Grabow, 2005) (Colorado, 2006) (Price, 1998) (Day, 2008) (Nader, 2005) See also stellate ganglion block.