

Case Number:	CM14-0136915		
Date Assigned:	09/03/2014	Date of Injury:	07/02/1997
Decision Date:	09/30/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	08/25/2014

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 Pain Management and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 patient is a 52 year old with an injury date on 7/2/97. Patient complains of decreased bilateral upper extremity pain with numbness/tingling rated 8/10, ongoing headaches, intermittent chest pain, and shortness of breath per 7/30/14 report. Patient states that pain is 8/10 with medications, and 10/10 without medications per 7/30/14 report. Based on the 7/30/14 progress report provided by [REDACTED] the diagnoses are: 1. degeneration of cervical intervertebral disc 2. cervicalgia 3. brachial neuritis or radiculitis nos 4. pain in soft tissues of limb 5. pain in joint: shoulder 6. pain in joint: upper arm 7. reflex sympathetic dystrophy of upper limb 8. headache 9. other syndromes affecting cervical region 10. other nerve root and plexus disorders 11. unspecified neuralgia neuritis and radiculitis 12. unspecified hereditary and idiopathic peripheral neuropathy Exam on 7/30/14 showed "C-spine range of motion is decreased. Patient has hyperalgesia and allodynia. Significant hyperalgesia from elbow to fingers. Decreased sensation to pinprick at bilateral C5, C6, C7, and left C8." [REDACTED] is requesting left stellate ganglion block. The utilization review determination being challenged is dated 8/19/14 and denies request as patient is not participating in a formal physical therapy program and still requires medication for headaches. [REDACTED] is the requesting provider, and he provided a treatment report from 7/30/14.

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 Treatment Guidelines Chronic Pain Medical Treatment Guidelines, CRPS, sympathetic blocks (therapeutic). Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 103-104, 39-40. Decision based on Non-MTUS Citation ODG-TWC, Pain Chapter CRPS, Sympathetic blocks (therapeutic) Recommend local anesthetic sympathetic blocks for limited, select cases, as indicated below. Not recommend IV regional anesthesia blocks. Local anesthetic sympathetic blocks: Recommended for limited, select cases, primarily for diagnosis of sympathetically mediated pain and therapeutically as an adjunct to facilitate physical therapy/ functional restoration. When used for therapeutic purposes the procedure is not considered a stand-alone treatment. The role of sympathetic blocks for treatment of CRPS is largely empirical (with a general lack of evidence-based research for support) but can be clinically important in individual cases in which the procedure ameliorates pain and improves function, allowing for a less painful "window of opportunity" for rehabilitation techniques. (Harden, 2013) Use of sympathetic blocks should be balanced against the side effect ratio and evidence of limited response to treatment. See CRPS, diagnostic tests. IV regional anesthesia: Not recommended due to lack of evidence for use. This procedure is a technique that allows placement of medications directly in the effected extremity but current literature indicates efficacy is poor. (Harden, 2013) There is no role for IV diagnostic blocks with phentolamine or IVRA with guanethidine. Other procedures include IV regional blocks with lidocaine, lidocaine-methyl-prednisolone, droperidol, ketanserin, atropine, bretylium clonidine, and reserpine. If used, there must be evidence that current CRPS criteria have been met and all other diagnoses have been ruled out. Evidence of sympathetically mediated pain should be provided (see the recommendations below). The reason for the necessity of this procedure over-and-above a standard sympathetic block should also be provided. (Perez, 2010) (Harden, 2013) (Tran, 2010) See also CRPS, treatment. General information on sympathetic procedures Current literature: A recent study indicated that there was low quality literature to support this procedure (some evidence of effect, but conclusions were limited by study design, divergent CRPS diagnostic criteria, differing injection techniques and lack of consistent criteria for positive response). Results were inconsistent and/or extrapolation of questionable reliability with inconclusive evidence to recommend for or against the intervention. (Dworkin, 2013) Other studies have found evidence non-conclusive for this procedure or that low-quality evidence showed this procedure was not effective. (O'Connell, 2013) (Tran, 2010) The blocks are thought to be most beneficial when used early in the disease as an adjunct to rehabilitation with physical or occupational therapy. No controlled trials have shown any significant benefit from sympathetic blockade. (Dworkin 2013) (O'Connell, 2013) (Tran, 2010) (van Eijs, 2012) (Perez, 2010) (van Eijs, 2011) (Nelson, 2006) (Varrassi, 2006) (Cepeda, 2005) (Hartrick, 2004) (Gr

Decision rationale: This patient presents with bilateral upper extremity pain. The treater has asked for left stellate ganglion block on 7/30/14. Patient states that prior stellate ganglion block on 6/30/14 gave greater than 20% relief per 7/30/14 report. Patient has tried and failed traditional migraine abatement medications such as Imitrex, due to severe GI upset and therefore relies heavily on fioricet and stellate ganglion blocks for relief of headaches per 7/30/14 report. Regarding regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, &

lumbar sympathetic block), MTUS recommends for CRPS. In this case, the patient presents with allodynia and hyperalgesia, hallmark symptoms of CRPS. However, the patient's prior stellate ganglion resulted in only 20% reduction of pain. There was no documentation of medication reduction. When reading ODG guidelines for repeat blocks, medication reduction is required. Recommendation is for denial.