

Case Number:	CM14-0147078		
Date Assigned:	09/15/2014	Date of Injury:	03/06/1999
Decision Date:	10/15/2014	UR Denial Date:	08/16/2014
Priority:	Standard	Application Received:	09/10/2014

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 Occupational Medicine 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 58-year-old female who has submitted a claim for reflex sympathetic dystrophy of upper limb associated with an industrial injury date of March 6, 1999. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of low back pain described as sharp, stabbing, burning, constant and radiating into the left leg. Pain was rated 3/10. Numbness, paresthesia and weakness were also reported. Examination revealed that the upper extremity had decreased ROM, discoloration, edema, decreased grasping reflex and decreased hand manipulation. Axial compression of the cervical spine caused right paracervical tenderness. There was also tenderness over the trapezial area and the cervical ROM was decreased. Upper extremity reflexes were diminished in the right biceps and sensation was diminished in the C5 and C6 dermatomes. Bilateral upper extremity motor strength was intact but the right upper extremity was swollen with hyperesthesia and allodynia. Treatment to date has included right stellate ganglion block on 2/24/2014 that provided 50-60% relief and enabled the patient to perform ADLs, showering, cleaning, cooking and dressing. A few weeks after the stellate ganglion block, on 3/11/2014, pain was 6-7/10 but decreased to 3/10 on 4/8/2014 and remained at this level until the most recent visit on 7/29/2014. Utilization review from August 16, 2014 denied the request for Right Stellate Ganglion Block, 1 Monitored Anesthesia Care, 1 Epidurography, 1 Prescription Roxicodone 30mg #180 and 1 Prescription Restoril 30mg #30. The request for stellate ganglion block was denied because the patient still had continuous benefits from the previous block and had not yet returned to pre-block levels. The request for anesthesia and epidurography was denied because guidelines do not show the necessity of anesthesia for stellate ganglion blocks and the request for the latter was not certified. The request for Roxicodone was denied because there was no evidence of pain or functional improvement

due to opioid therapy. The request for Restoril was denied because guidelines limit its use to short term.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Stellate Ganglion Block: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRPS, Sympathetic and Epidural Blocks Regional sympathetic blocks (stellate ganglion block, tho.

Decision rationale: As stated on pages 103-104 of CA MTUS Chronic Pain Medical Treatment Guidelines, there is limited evidence to support stellate ganglion block (SGB), with most studies reported being case studies. This block is proposed for the diagnosis and treatment of sympathetic pain involving the face, head, neck, and upper extremities. Proposed indications for pain include: CRPS; herpes zoster and post-herpetic neuralgia; and frostbite. Stellate ganglion blocks are recommended only for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. Repeat blocks are only recommended if continued improvement is observed. In this case, patient received right stellate ganglion block on 2/24/2014 that provided 50-60% relief and enabled the patient to perform ADLs, showering, cleaning, cooking and dressing. Pain was slowly reduced to 6-7/10 2 weeks after the procedure to 3/10. However, progress report from 07/29/2014 revealed that patient's right upper extremity symptom is becoming worse leading to a decrease in quality of life and new onset of right hand weakness. Repeat block may be warranted at this time. Therefore, the request for Right Stellate Ganglion Block is medically necessary.

1 Monitored Anesthesia Care: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Statement on Anesthetic Care During Interventional Pain Procedures for Adults, American Society of Anesthesiologists, 2005

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, an article endorsed by the American Society of Anesthesiologists was used instead. It states that procedures that are prolonged and/or painful often require intravenous sedation and may warrant use of monitored anesthesia care (MAC). These include sympathetic blocks (stellate ganglion, celiac plexus, lumbar paravertebral), radiofrequency ablation (R/F), discography, etc. In this case, patient has been certified to undergo right stellate ganglion block. Intravenous sedation is requested to minimize patient's anxiety from spinal injections. MAC is

recommended for sympathetic blocks. Guideline criteria are met. Therefore, the request for 1 monitored anesthesia care is medically necessary.

1 Epidurography: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Section, CRPS, Treatment

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG) was used instead. It states that epidural infusion for sympathetic blockade is not recommended due to lack of evidence for use and high risk of complications including infection. There is one randomized controlled trial that reported improvement. A study that included both randomized and open label design (26 patients) using clonidine showed pain relief, but the authors considered this experimental and the study has not been repeated. Infections occurred in 6/19 patients who ultimately received the treatment. In this case, patient has been certified to undergo right stellate ganglion block. However, there is no discussion concerning need for epidurography when the guideline does not strongly support its use. The medical necessity cannot be established due to insufficient information. Therefore, the request for epidurography is not medically necessary.

1 Prescription Roxicodone 30mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines: Opioids for chronic pai.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-81.

Decision rationale: Pages 78-81 of the CA MTUS Chronic Pain Medical Treatment Guidelines states that four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potential aberrant (or non-adherent) drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. Guidelines also state that the lowest possible dose should be prescribed to improve pain and function, continuing review of overall situation with regard to nonopioid means of pain control. In this case, the patient has been opioids since at least 4/23/2013. In fact, Percocet was recommended for weaning at this time due to no evidence of overall improvement of function. There is continued absence of evidence of pain or functional improvement secondary to opioid therapy. Recent pain reduction was attributed to the ganglion block. Therefore, the request for 1 Prescription Roxicodone 30mg #180 is not medically necessary.

1 Prescription Restoril 30mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Opioids for chronic pain

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26, Benzodiazepines, Page(s): 24.

Decision rationale: As stated on page 24 of CA MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. In this case, patient has been on Restoril since July 1, 2014. However, there is no documentation concerning functional improvement from medication use. Moreover, there is no discussion on the characteristics of the sleep problem and sleep hygiene. The medical necessity has not been established due to insufficient information. Therefore, the request for 1 Prescription Restoril 30mg #30 is not medically necessary.