MAXIMUS Federal Services

Case Number:	CM15-0177587		
Date Assigned:	09/18/2015	Date of Injury:	08/29/2001
Decision Date:	10/21/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	09/09/2015

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: North Carolina
Certification(s)/Specialty: Family Practice

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 8-29-2001. The mechanism of injury is not detailed. Diagnoses include left upper extremity chronic regional pain syndrome, left shoulder impingement syndrome, left leg pain, and low back pain with disc herniations. Treatment has included oral medications and work hardening program. Physician notes dated 8-6-2015 show complaints of severe low back pain with radiation to the left lower extremity and migraines. The physical examination shows PHQ-score is 21 out of 30 indicating severe depressive symptoms, left shoulder abduction is 40 degrees with pain at the end range, left hand is slightly swollen and cool to the touch, straight leg raise is positive on the left, 3 out of 5 pain-limited ankle dorsiflexors and evertors, 5 out of 5 on the right, 4+ out of 5 left knee flexors, and 5 out of 5 on the right. Recommendations include changing one of three approved right upper extremity stellate ganglion blocks to the left side, complete physical therapy and work hardening sessions, lumbar sympathetic blocks, lumbar spine CT scan, and follow up in one month.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left upper extremity ganglion block: Upheld

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).

Decision rationale: The California MTUS section on CRPS states: CRPS, sympathetic and epidural blocks: Recommended only as indicated below, for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. Detailed information about stellate ganglion blocks, thoracic sympathetic blocks, and lumbar sympathetic blocks is found in Regional sympathetic blocks. Recommendations for the use of sympathetic blocks are listed below. They are recommended for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. It should be noted that sympathetic blocks are not specific for CRPS. See Sympathetically maintained pain (SMP). Repeated blocks are only recommended if continued improvement is observed. The requested service is not being used for diagnosis of sympathetically mediated pain. It is also not being used as an adjunct to facilitate physical therapy. Therefore, the request is not medically necessary.

Left lumbar sympathetic block x 3: Upheld

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).

Decision rationale: The California MTUS section on CRPS states: CRPS, sympathetic and epidural blocks: Recommended only as indicated below, for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. Detailed information about stellate ganglion blocks, thoracic sympathetic blocks, and lumbar sympathetic blocks is found in Regional sympathetic blocks. Recommendations for the use of sympathetic blocks are listed below. They are recommended for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. It should be noted that sympathetic blocks are not specific for CRPS. See Sympathetically maintained pain (SMP). Repeated blocks are only recommended if continued improvement is observed. The requested service is not being used for diagnosis of sympathetically mediated pain. It is also not being used as an adjunct to facilitate physical therapy. Therefore, the request is not medically necessary.

CT scan lumbar: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Computed Tomography.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.