

Case Number:	CM15-0179422		
Date Assigned:	09/21/2015	Date of Injury:	06/07/2013
Decision Date:	10/29/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	09/11/2015

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, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 47-year-old male who sustained an industrial injury on June 7, 2013. Diagnoses have included lumbar spinal stenosis, spondylolisthesis, lumbar radiculopathy, lumbar disc disorder, and arthropathy. Documented treatment includes a lumbar fusion at L3-4 and L4-5 in March, 2014 which was stated in the July 6, 2015 note as providing "no improvement"; physical therapy; two lumbar epidural injections in 2014 with relief lasting one week with the first, but no relief from the second; use of a rigid brace; and, medication including Naproxen, Norco, Ultram, and Tramadol. At the July 28, 2015 examination, the injured worker continued to report severe back pain rated as 9 out of 10 and radiating down both legs with numbness and tingling. His pain has been aggravated with activity and interfering with most activities of daily living. He was noted to walk with an antalgic gate while being stooped forward and he has been unable to sit, stand or walk for more than 10 minutes without pain. His range of motion was documented as flexion 30 degrees with pain; extension 10 degrees with pain; and right and left lateral flexion were both 15 degrees. Straight leg raise was positive bilaterally with the right causing low back pain. The treating physician is considering a trial of dorsal column stimulator and the plan of care includes a lumbar sympathetic block, which was denied on August 21, 2015. The injured worker has not been working.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar sympathetic block: 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): Regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, & lumbar sympathetic block).

Decision rationale: The records indicate the patient has ongoing low back pain and pain traveling into the lower extremities following back surgery. The current request for consideration is a lumbar sympathetic block. The attending physician report dated 7/6/15, page (59b), states that due to ongoing radiating symptoms into the lower extremities and the failed back surgery, he is a candidate for a sympathetic block of the lumbar spine to rule out any CRP which could be causing ongoing low back pain and radiating symptoms. The CA MTUS has this to say regarding lumbar sympathetic blocks: Recommendations are generally limited to diagnosis and therapy for CRPS. Stellate Lumbar Sympathetic Blocks: There is limited evidence to support this procedure, with most studies reported being case studies. Anatomy: Consists of several ganglia between the L1 and L5 vertebra. Proposed Indications: Circulatory insufficiency of the leg: (Arteriosclerotic disease; Claudication: Rest pain; Ischemic ulcers; Diabetic gangrene; Pain following arterial embolus). Pain: Herpes Zoster; Post-herpetic neuralgia; Frostbite; CRPS; Phantom pain. These blocks can be used diagnostically and therapeutically. Adjunct therapy: sympathetic therapy should be accompanied by aggressive physical therapy to optimize success. Complications: Back pain; Hematuria; Somatic block; Segmental nerve injury; Hypotension (secondary to vasodilation); Bleeding; Paralysis: Renal puncture/trauma. Genitofemoral neuralgia can occur with symptoms of burning dysesthesia in the anteromedial upper thigh. It is advised to not block at L4 to avoid this complication. Adequacy of the block: This should be determined, generally by measure of skin temperature (with an increase noted on the side of the block). Complete sympathetic blockade can be measured with the addition of tests of abolition of sweating and of the sympathogalvanic response. In this case, the attending physician is attempting to rule in or rule out complex region pain syndrome as a possible explanation for the patient's ongoing complaints. The CA MTUS does recommend the use of lumbar sympathetic blocks for diagnostic purposes. The current request appears reasonable and consistent with MTUS guidelines and is therefore medically necessary.