



791 Highway 77 North, Suite 501C-316 Waxahachie, TX 75165
Ph 972-825-7231 Fax 972-775-8114

Notice of Independent Review Decision

DATE OF REVIEW: 1/17/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an outpatient stellate ganglion block to the left wrist.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer has been practicing for greater than 10 years.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of an outpatient stellate ganglion block to the left wrist.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury xx/xx/xx. The injured worker fainted and fell to the concrete, twisting the left wrist. Initial treatment on the day of injury included a Toradol injection and a left wrist splint. On follow-up xx/xx the pain involved the left wrist and the neck. An arm sling was prescribed and a course of prednisone was started. On the next follow-up visit 7/26/2010 the steroids were not helping. Prednisone was continued and a request was made for MRI of the wrist and cervical spine. On the follow-up visit 08/03/2010 the MRI results were reviewed. Physical therapy was requested for treatment of cervical

strain. Arrangements were made for transfer to a worker's comp physician.

Physical therapy evaluation was done at the Center on August 16, 2010. The therapist noted decreased cervical mobility with severe muscle guarding. There was a limitation of "left upper extremity" range of motion (specific joints were not mentioned). On August 18 the therapist noted that the left wrist was giving the patient a lot of problems. Therapy was directed toward the cervical spine, but also included pulleys for shoulder range of motion. There was left wrist pain when doing light shoulder exercises.

Dr. saw the injured worker August 24, 2010 for evaluation and treatment. Dr. provided a steroid injection in the office, which gave significant relief of the patient's pain, but not complete relief. Examination revealed a painful, snapping extensor carpi ulnaris tendon, and placed a long-arm cast with the forearm pronated. "If her symptoms improve after 3 weeks of casting, we will convert her to a Munster cast. If she does not have any improvement in her symptoms at that time, we will consider reconstruction of the extensor carpi ulnaris tendon sheath".

On the follow-up visit September 9, 2010 pain throughout the left upper extremity was aggravated by movement. Dr. felt that "the most severe cause of her pain is actually brachial neuritis. That would explain the global pain syndrome throughout the arm radiating up into the shoulder and neck. I do think that the extensor carpi ulnaris issue is a significant one". Dr. referred the injured worker to Center September 13, 2010 for outpatient therapy. The examining therapist recorded a chief complaint of shooting pain running along the ulnar side of the hand all the way up to the neck.

Pain was aggravated with movement of the shoulder and during forearm rotation. On examination there was a subluxing extensor carpi ulnaris tendon on the left, with increased pain shooting and radiating throughout the entire left upper extremity.

Dr. referred the injured worker to the, where she was seen in consultation by Dr. September 15, 2010. There was severe pain in the left wrist, fingers and shoulder especially with certain movement. The handwritten notes in the examination record mentioned the following: "extremely sensitive to light touch and slight percussion over the left (unreadable). Skin mottling. Increased capillary refill time greater than six seconds. Grip 3-/5".

On the follow-up visit September 21, 2010 Dr. noted that the injured worker presented with significant improvement in her left arm pain after seeing Dr.. He felt that the injured worker "has some wrist pathology that will need to be addressed in the future, but I think one month of seeing how the Lyrica works that was given to her by Dr. would be wise. I placed her on work restrictions involving the use of her left arm, and she can follow up in 1 month".

On the follow-up visit to the September 29, 2010 the Lyrica had been helpful but caused drowsiness. Wrist pain persisted, traveling to the left shoulder. A stellate ganglion block was planned, pending authorization. According to an unidentified handwritten medical record October 6, 2010 the injured worker reported difficulty closing the left hand. There was decreased motion of the neck, left wrist, and the left hand/fingers. The shoulders had decreased range of motion. Lyrica was increased to 75 milligrams twice daily. At the October 12, 2010 the injured worker reported no improvement.

In October 2010 gave notice of disputed issues and refusal to pay benefits except for a

cervical, left forearm and left wrist strain only. On October 12, 2010 Dr. noted that the injured worker's pain increased when she stopped taking Lyrica so she could work. Dr. noted global pain "which is a result of either sympathetic-mediated pain syndrome or brachial neuritis." On the follow-up visit October 26, 2010 Dr. noted the "continuing pain in the left arm that does not fit the various mechanical diagnoses that I have suspected. It seems to be neurological in origin. It is possibly due to brachial neuritis. She is being treated by Dr. for brachial neuritis or other regional pain syndrome".

Dr. performed a left stellate ganglion block November 2, 2010 at Hospital. Preoperative and postoperative pain scores were recorded but the actual scores were not included in the report and were not submitted for this review. On the follow up outpatient visit November 5, 2010 the injured worker explained that since the procedure "pain is more consistent & seems to have gotten worse, especially in cold". On the pain diagram marks were made over the left shoulder, supraclavicular area and wrist. The "current pain score" was 8. She had to double up on the Lyrica. EMG and nerve conduction studies November 16, 2010 were reported to be within normal limits. On 11/22/2010 Dr. requested authorization for left stellate ganglion block.

An IRO appeal request was submitted November 22, 2010 with the following comments: "Although this patient showed only moderate improvement after the original SG Block... It allowed her to regain daily function and increased activity for an extended period. Please reconsider this procedure for authorization. Thank you".

The proposed procedure was non-authorized 11/30/2010. The non-authorization was upheld on reconsideration 12/15/2010. On 12/27/2010 Dr. requested review by an IRO. On the follow-up visit to the 12/14/2010 the injured worker answered the question regarding new pain symptoms since the last visit with the statement "more pain over elbow to shoulder". In the HPI portion of the note (some of the handwriting is illegible): "continues with pain in the left forearm/top of wrist and into the upper arm. [Getting] better. Meds are somewhat effective. Lyrica helps (illegible) with nerve pain. Norco-- takes edge off and helps with activity levels for short period of time. Better feeling since the block". The examination notes report "no changes in exam findings". Plans include "[Psych] referral for CBT, continue medications, continue home exercise program/strengthening".

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

In summary, the injured worker's complaints and physical findings are consistent with a diagnosis of CRPS or shoulder hand syndrome. The note from 12/14/2010 does include documentation of some clinical improvement (between 11/02/2010 and 12/14/2010). The note does refer to an ongoing home exercise program. Therefore a second *diagnostic* stellate ganglion block would be justifiable. Subsequent progression to a series of *therapeutic* blocks would not be justifiable without better documentation of the response to therapy, the use of medications, and the functional status, etc., as outlined in the ODG Guidelines (see below).

DISCUSSION

1. The follow-up outpatient visit to the 12/14/2010 occurred after non- authorization of the second stellate ganglion block, one day before notification that the non-authorization had been upheld on appeal. In that follow up visit (12/14/2010) the injured worker

reported “more pain over elbow to shoulder.” The HPI portion of the note (some of which is illegible) mentioned some improvement since the block. An ongoing home exercise strengthening program was mentioned. Based upon the information in this note, there apparently had been some clinical improvement (between 11/02/2010 and 12/14/2010) but there was some new pain in the involved area as of 12/14/2010.

2. Regarding adequacy of the sympathetic block: the ODG Integrated Treatment/Disability Duration Guidelines for Pain (Chronic) (updated 12/15/10), pertaining to CRPS, diagnostic criteria and Regional sympathetic blocks, state the following:

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%)....

3. Documentation of the initial response to the sympathetic block apparently was done but was not submitted for review. The operative report from 11/02/2010 states that the preoperative and postoperative pain scores were recorded, but the actual pain scores were not made available for review. According to the ODG Guidelines pertaining to recommendations (based on consensus guidelines) for use of sympathetic blocks: sympathetic block consistently gives 90 to 100 percent relief each time a technically good block is performed (with measured rise in temperature)... In the initial diagnostic phase if less than 50% improvement is noted for the duration of the local anesthetic, no further blocks are recommended.

4. Pertaining to the therapeutic phase:

- In the initial therapeutic phase, maximum sustained relief is generally obtained after 3 to 6 blocks. These blocks are generally given in fairly quick succession in the first two weeks of treatment with tapering to once a week. Continuing treatment longer than 2 to 3 weeks is unusual.
- In the therapeutic phase repeat blocks should only be undertaken if there is evidence of increased range of motion, pain and medication use reduction and increased tolerance of activity and touch (decreased allodynia) in physical therapy/occupational therapy.
- There should be evidence that physical or occupational therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase.
- In acute exacerbations, 1 to 3 blocks may be required for treatment.
- A formal test of the block should be documented (preferably using skin temperature).
- Documentation of motor and/or sensory block should occur. This is particularly important in the diagnostic phase to avoid overestimation of the sympathetic component of pain.

The requested procedure is found to be medically necessary at this time based upon the records received.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)