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Notice of Independent Review Decision

DATE OF REVIEW: November 17, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left stellate ganglion block

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

American Board of Physical Medicine & Rehabilitation

American Board of Pain Medicine

REVIEW OUTCOME

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

X Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Utilization reviews (10/11/11 – 10/28/11)
- Office visits (11/04/10 – 10/11/11)
- Utilization reviews (10/11/11 – 10/28/11)
- Office visits (11/04/10 – 10/11/11)
- Office visits (11/04/10 – 10/03/11)
- Utilization reviews (10/11/11 – 10/28/11)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who injured her left elbow on xx/xx/xx, thereby injuring the ulnar nerve.

1999 – 2009: No records available.

2010: On November 4, 2010, performed an electromyography/nerve conduction velocity (EMG/NCV) study for complaints of pain in the left elbow. Treatment history revealed: *The patient had hurt her left ulnar nerve and had subsequently undergone three surgeries for that. She had had some chronic weakness in the left hand ever since. She had been having some pain in the neck and back and was trying to exercise to make herself stronger but unfortunately had come down with a seizure disorder.* Examination of the left elbow revealed scar and tenderness over the left elbow, weakness in finger abduction, weak handgrip and numbness in the ulnar distribution. The study just revealed chronic ulnar neuropathy in the left elbow.

from, noted chronic ulnar neuropathy and chronic involvement of the first dorsal interosseous abductor digit minimi and little tingling and numbness. The patient was utilizing Valium and Zanaflex for spasms and Lidoderm patch for tingling and burning. Examination revealed weakness in the first dorsal interosseous abductor digit minimi, positive Tinel's down the ulnar nerve and diminished sensation to pinwheel and pinprick along the distribution of the hand. diagnosed lesion of ulnar nerve and continued medications.

In December, noted spasms in the arm. The patient had had a nerve decompression and the nerves had scarred her badly. had done intramuscular transposition to help free the nerve but the patient continued with pain and spasms in the forearm and some vasospasm due to mild increased sympathetic tone to the arm due to the nerve damage. He recommended a stellate block to help with the vasospasm and prescribed Lunesta for sleep.

from, noted left upper extremity pain and chronic intractable pain syndrome. He diagnosed left ulnar nerve injury, lesion of ulnar nerve and chronic intractable pain syndrome; scheduled the patient for possible ulnar nerve injection and reinitiated Lyrica, Zanaflex and Lunesta.

2011: In April, noted increased sympathetic tone and sensitivity and spasm in the left upper extremity. The patient still had some weakness of the intrinsic, numbness and tingling in the hand. treated her with a block just above the ulnar nerve and continued Valium and Lyrica.

In August, he noted chronic left ulnar neuritis. The patient was using Flector patches over her elbow. If there was no improvement, repeat neurolysis would be considered.

In October, noted continued significant symptomatology. Examination of the left elbow revealed pain with any type of movement and palpation, as well as flexion and extension. Several years ago, the patient had had a left stellate ganglion nerve block, which had been helpful in relieving her pain for sometime. recommended another stellate ganglion injection on the left, refilled Lunesta, prescribed Ambien and discontinued Lyrica.

On October 11, 2011, denied the request for outpatient left stellate ganglion block based on the following rationale: *"Stellate ganglion blocks were generally limited to diagnosis and therapy for complex regional pain syndrome (CRPS). As there were no findings indicating CRPS, there was insufficient documentation or*

rationale for an outpatient left stellate ganglion block related to the left upper extremity, thus the request was not medically reasonable and necessary.”

In a letter of appeal, opined he had already submitted the findings of allodynia, hyperesthesia, hypertrichosis, pseudomotor changes as well as muscle wasting which all went with CRPS. Hence, the stellate ganglion blocks were recommended for diagnostic and therapeutic treatment for CRPS, which the patient had been diagnosed with.

On October 28, 2011, denied the appeal for outpatient left stellate ganglion block based on the following rationale: *“There was insufficient documentation or rationale. After review of the supplied documentation, clinical findings of allodynia and hyperalgesia were documented. There was no clinical documentation provided establishing hypertrichosis, pseudomotor changes or muscle atrophy. Even the provider’s proposed future treatment plan (proposing additional neurolysis) does not support that CRPS is suspected as CRPS is a relative contraindication for further surgery. Thus, the procedure is not authorized.”*

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

The previous reviews stated, “As there are no findings indicating CRPS, there is insufficient documentation or rationale for an outpatient stellate ganglion block related the left upper extremity, thus the requests not medically reasonable or necessary” and “After review of the supplied documentation, clinical findings of alloydynia and hyperalgesia are documented. There is no clinical documentation provided establishing hypertrichosis, sudomotor changes, or muscle atrophy”.

According to the ODG, The IASP (International Association for the Study of Pain) has defined this diagnosis as a variety of painful conditions following injury which appear regionally having a distal predominance of abnormal findings, exceeding in both magnitude and duration the expected clinical course of the inciting event and often resulting in significant impairment of motor function, and showing variable progression over time. (Stanton-Hicks, 1995) Diagnostic criteria defined by IASP in 1995 were the following: (1) The presence of an initiating noxious event or cause of immobilization that leads to development of the syndrome; (2) Continuing pain, allodynia, or hyperalgesia which is disproportionate to the inciting event and/or spontaneous pain in the absence of external stimuli; (3) Evidence *at some time* of edema, changes in skin blood flow, or abnormal sudomotor activity in the pain region; & (4) The diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain or dysfunction.

Criteria 2-4 must be satisfied to make the diagnosis. According to the second review, criteria #3 was not satisfied. However, after a thorough review of the available notes, vasospasm was documented in 2010, “had done intramuscular transposition to help free the nerve but the patient continued with pain and spasms in the forearm and some vasospasm due to mild increased sympathetic tone to the arm due to the nerve damage”. The vasospasm is that which causes

the changes in the color and temperature of the skin. Thus, criteria 2-4 were, in fact, satisfied per the documentation prior to the reviews.

The pertinent section of the ODG on CRPS that addresses sympathetic blocks provides as follows:

- “Recommended only as indicated, for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy.
- *Testing for an adequate block:* 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%). Complete sympathetic blockade can be measured with the addition of tests of abolition of sweating and of the sympathogalvanic response. Documentation of motor and/or sensory block should occur.
- Per the Official Disability Guidelines, a patient’s “pain relief should be 50% or greater for the duration of local anesthetic” when a diagnostic stellate ganglion block is performed. In addition, “pain relief should be associated with functional improvement” from the diagnostic stellate ganglion block.

In conclusion, the stellate ganglion block should be approved as the documentation meets the criteria set forth per the ODG. In addition, any future requested blocks must meet the criteria as outlined above per the ODG.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**