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Notice of Independent Review Decision

Date notice sent to all parties:

August 14, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Injection, anesthetic agent; Stellate ganglion (cervical sympathetic)

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

Board Certified Anesthesiology /Pain Management

REVIEW OUTCOME:

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

x Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Operative reports 11/16/10-02/23/12
MRI right shoulder 06/17/11 and 01/30/12
Clinical note 06/21/12
Prior reviews 06/29/12 and 07/13/12
Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. The patient is status post right shoulder glenohumeral arthroscopy with labral debridement and biceps tenodesis on 11/16/10. The patient had two subsequent arthroscopic repairs in the right shoulder on 07/20/11 and 02/23/12. The patient presented on 06/21/12 with complaints of persistent pain in the right shoulder. The patient also reported sensitivity and tingling in the right upper extremity. Current medications at this visit

include hydrocodone and Tylenol. The patient is noted to be a half pack to one pack per day smoker. Physical examination at this visit revealed mild hyperesthesia to light touch along the right shoulder. The patient was assessed with possible chronic regional pain syndrome and was prescribed Norco, Elavil, and Lyrica. The request for a right stellate ganglion block of the right shoulder was denied by utilization review on 06/29/12 due to lack of objective evidence to support a diagnosis of chronic regional pain syndrome. The request for right stellate ganglion block of the shoulder was again denied by utilization review on 07/13/12 due to lack of objective evidence to support a diagnosis of CRPS.

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

The request for stellate ganglion block of the cervical sympathetic nerve is not recommended as medically necessary based on the clinical documentation provided for review. The clinical documentation does not support a diagnosis of CRPS. Patient's most recent physical examination revealed mild hypersensitivity in the right upper extremity at the shoulder area. There were no objective findings of skin mottling, temperature differences, allodynia, or hypertrophic growth that are the key markers for diagnosis of CRPS. No diagnostic testing was performed to further support a diagnosis of CRPS such as electrodiagnostic studies. Given the lack of objective findings consistent with CRPS, the request for right stellate ganglion block for the shoulder would not be considered medically necessary based on current evidence based guidelines.

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

- x MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- x ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

ODG Pain Chapter

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. Systematic reviews reveal a paucity of published evidence supporting the use of local anesthetic sympathetic blocks for the treatment of CRPS and usefulness remains controversial. Less than 1/3 of patients with CRPS are likely to

respond to sympathetic blockade. No controlled trials have shown any significant benefit from sympathetic blockade. ([Varrassi, 2006](#)) ([Cepeda, 2005](#)) ([Hartrick, 2004](#)) ([Grabow, 2005](#)) ([Cepeda, 2002](#)) ([Forouzanfar, 2002](#)) ([Sharma, 2006](#)) *Predictors of poor response:* Long duration of symptoms prior to intervention; Elevated anxiety levels; Poor coping skills; Litigation. ([Hartrick, 2004](#)) ([Nelson, 2006](#)) *Alternatives to regional sympathetic blocks:* may be necessary when there is evidence of coagulopathy, systemic infection, and/or post-surgical changes. These include peripheral nerve and plexus blocks and epidural administration of local anesthetics. *Mixed conduction blocks (central neural blocks):* suggested when analgesia is insufficient by pharmacologic means to support physical therapy: (1) Implanted catheters at the brachial or lumbosacral plexus: allows for 1 to 2 weeks of therapy. Side effects include technical failure and infection; & (2) Epidural tunneled catheters: allows for long-term therapy: Side effects: same as above. *Clonidine* has also been effective epidurally. ([Stanton-Hicks, 2006](#)) *Baclofen* has been demonstrated to be effective intrathecally to reduce dystonia. ([van Hilten, 2000](#)) *IV regional sympathetic blocks:* controversial due to varying success. Guanethadine was used, but is no longer available in the US. Bretylium and reserpine require daily blocks, and have potential side effects of transient syncope with apnea, orthostatic hypotension, pain with administration, nausea and vomiting. Bretylium provided more than 30% pain relief for a mean of 20 days compared to placebo. ([Hord, 1992](#)) Due to modest benefits and the invasiveness of the therapies, epidural clonidine injection and intravenous regional sympathetic block with bretylium should be offered only after careful counseling, and they should be followed by intensive physical therapy. Intravenous regional sympathetic block (Bier's block) with guanethidine and lidocaine resulted in excellent pain relief and full restoration of both function and range of movement of the affected extremity in patients suffering from CRPS-I of the hand. ([Paraskevas, 2005](#)) Local or systemic parecoxib combined with lidocaine/clonidine IV regional analgesia is an effective treatment for CRPS-I in a dominant upper limb. ([Frade, 2005](#)) See also [Sympathetically maintained pain \(SMP\)](#); & [Regional sympathetic blocks](#).

Recommendations (based on consensus guidelines) for use of sympathetic blocks: (1) In the initial diagnostic phase if less than 50% improvement is noted for the duration of the local anesthetic, no further blocks are recommended. (2) 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. (3) 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. (4) There should be evidence that physical or occupational therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase. (5) In acute exacerbations, 1 to 3 blocks may be required for treatment. (5) A formal test of the block should be documented (preferably using skin temperature). (6) 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. ([Burton, 2006](#)) ([Stanton-Hicks, 2004](#)) ([Stanton-Hicks, 2006](#)) ([International Research Foundation for RSD/CRPS, 2003](#)) ([Colorado, 2006](#)) ([Washington, 2002](#)) ([Rho, 2002](#))