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Notice of Independent Review Decision

December 14, 2012

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:

Board Certified Physical Medicine, Rehabilitation and Pain Management Physician

REVIEW OUTCOME:

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

☒ Overturned (Disagree)

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

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:

TDI

- Utilization reviews (09/18/12, 10/02/12)

- Office visits (11/04/11 - 09/11/12)
- Diagnostics (12/01/11 – 08/17/12)
- Reviews (09/14/12, 09/28/12)

- Utilization reviews (09/18/12, 10/02/12)

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is female who on xx/xx/xx, sustained injury to her bilateral wrists secondary to keyboarding/mouse work all day.

2011: On November 4, 2011, M.D., evaluated the patient for pain, tingling and numbness in the wrists and hands bilaterally. The symptoms were greatest on the left. The pain in the right hand was 6/10 and moderate in nature. The left side pain was sharp and moderate-to-severe with a rating of 7/10. Her additional symptoms were loss of bladder control and range of motion (ROM) limitation. She had attended physical therapy (PT). She had two months of persistent numbness, tingling and lancinating pain in the median nerve distribution in both wrists. History was positive for elevated cholesterol. Review of systems (ROS) was positive for abdominal pain. Examination of the wrists showed positive Phalen's and exquisitely positive Tinel's sign on both sides, difficult Scratch collapse test due to severe pain in the wrists and positive compression test bilaterally. X-rays of the wrists were unremarkable. Dr. assessed bilateral carpal tunnel syndrome (CTS) and recommended nerve conduction velocity (NCV) study and right endoscopic carpal tunnel release (CTR).

On December 1, 2011, electromyography/nerve conduction velocity (EMG/NCV) of the bilateral upper extremities showed normal EMG study but abnormal NCV study. There was prolonged sensory latency with stimulation of the left and right median nerves along injury and slowing seen in the wrist to palm segment of both median nerves indicating probable trauma or entrapment of both median nerves at the wrist and bilateral CTS.

2012: On January 18, 2012, the patient was two weeks status post right endoscopic CTR. The CTS had completely resolved. Examination showed mild right wrist stiffness. Dr. noted the patient was doing well and had slowly returning to normal activity. He recommended proceeding with left CTR.

On February 9, 2012, Dr. performed left endoscopic CTR.

On February 24, 2012, Dr. noted the patient had some residual ecchymosis and swelling in the region of the incision. The patient reported complete resolution of numbness, tingling and pain but some irritation involving the flexor pollicis longus (FPL) of the thumb which was improving daily. Examination showed some fullness in the area of the wrist secondary to residual swelling. Dr. recommended holding off on work for two more weeks and considering hand therapy if no improvement seen.

On March 9, 2012, Dr. noted that the patient had resolution of numbness and tingling but she had persistent pain along the FPL. Examination showed mild swelling and some local tenderness in the region of the incision. Dr. assessed mild FPL tenosynovitis after endoscopic CTR and recommended hand therapy.

On April 11, 2012, the patient underwent therapy evaluation at Orthopedic & Occupational Rehabilitation. The treatment plan was for eight sessions of therapy consisting of icepack, active range of motion (ROM), stretching of flexor forearm, wrist strengthening with Thera-Band as tolerated, scar massage, use of moist heat and home exercise program (HEP).

On June 27, 2012, Dr. noted that the patient had pain, tingling and numbness bilaterally at the wrist and hand. The symptoms were greatest on the left. The patient reported no improvement after her corticosteroid injection. She was recommended multiple ergonomic changes at her workstation. Examination of the left wrist showed some fullness over the flexor carpi radialis (FCR) insertion, tenderness of the FCR and pain with resisted wrist flexion. Dr. assessed left FCR tenosynovitis, discussed opinion of injection versus tenosynovectomy and recommended a custom molded wrist splint.

On August 17, 2012, MRI of the left wrist showed status post CTR with findings suggesting possibility of retinacular regrowth, with scar tissue bridging the gap at the site of release of the transverse carpal ligament. There was mild edema in the thenar musculature possibly suggesting recurrent CTS and clinical correlation was recommended.

On August 29, 2012, Dr. reviewed the MRI findings. Examination of the left wrist showed some fullness over the FCR insertion, positive tenderness of the FCR and pain with resisted wrist flexion. The midcarpal clunk test was positive and much more prominent on the symptomatic left wrist than the right. Dr. assessed left FCR tenosynovitis and left greater than right midcarpal instability, prescribed Ultram and recommended pain management consultation.

On September 11, 2012, PA-C, evaluated the patient for bilateral carpal tunnel and wrist pain. The patient had aching, dull and throbbing wrist pain bilaterally. The pain worsened with any activity involving the left arm. Her sleep was interrupted due to pain. She had undergone treatment consisting of PT, surgery, injections, massage and chiropractic treatment. History was positive for attention deficit disorder and obsessive compulsive disorder. ROS was positive for aching, limitation of joint movement, morning stiffness, swelling and tenderness. Examination showed bilateral wrist tendon tenderness, temperature changes and allodynia. Mr. assessed CTS, pain in the hand and reflex sympathetic dystrophy (RSD) of the upper extremity; prescribed Lyrica, Naprosyn and recommended a stellate ganglion block.

Per the utilization review dated September 18, 2012, the request for stellate ganglion block (series of three) for **bilateral** wrists was denied with the following rationale: *"The submitted physical examination is not detailed and fails to establish the presence of RSD/CRPS. There is no indication that the claimant has had treatment for possible RSD prior to attempting the blocks. Follow up note dated September 11, 2012, indicates that there is hand/wrist tenderness-tendon bilateral. There is no nail change. Skin color is normal. Sensation is intact*

throughout. There is noted to be a temperature change (no measurements provided) and allodynia."

On September 28, 2012, a request was submitted for reconsideration of stellate ganglion blocks (series of 3) left wrist.

Per the reconsideration review dated October 2, 2012, the request for stellate ganglion blocks (series of three) of the **left** wrist was denied with the following rationale: *"The claimant has only just started neuropathic medications for her condition. The physical exam indicates allodynia and temperature changes but does not delineate which side or if there are any other findings. The claimant had bilateral pain. A series is not indicated since the first injection determines if more are needed based on its result and there was no provider contact to modify. For all these reasons, the Stellate Ganglion Blocks are non-authorized."*

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

Diagnosis of CRPS per the ODG, recommends using a combination of criteria. There are no objective gold-standard diagnostic criteria for CRPS I or II. A comparison between three sets of diagnostic criteria for CRPS I concluded that there was a substantial lack of agreement between different diagnostic sets. According to the ODG, at least 1 symptom reported in at least 3 of the following categories:
◦Sensory: Hyperesthesia or allodynia
◦Vasomotor: Temperature asymmetry, skin color changes, skin color asymmetry
◦Sudomotor/edema: Edema, sweating changes, or sweating asymmetry
◦Motor/trophic: Decreased range of motion, motor dysfunction (eg, weakness, tremor, dystonia), or trophic changes (eg, hair, nail, skin).

The physical exam findings demonstrate allodynia and temperature asymmetry. August 17, 2012, MRI demonstrates mild edema within the thenar musculature. Three of four criteria are met for the diagnosis of CRPS 1.

ODG recommendations (based on consensus guidelines) for use of sympathetic blocks: In the initial diagnostic phase if less than 50% improvement is noted for the duration of the local anesthetic, no further blocks are recommended. 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.
Thus, one diagnostic left stellate ganglion block is approved.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**