

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 12/27/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Right Wrist Radial Stellate Ganglion Injection

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

Texas Board Certified Anesthesiologist

Texas Board Certified Pain Medicine

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Clinical notes dated 06/01/11 through 11/11/11 by
2. Clinical note dated 08/18/11 by
3. MRI of the upper extremity joint without contrast by dated for 06/13/11
4. Per reviews dated for 10/26/11 and 11/03/11
5. Other working documents
6. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who reported an injury on xx/xx/xx.

According to clinical note dated 06/01/11, the employee has a chief complaint of right wrist pain. The employee stated that he was working and was very busy and stated he had significant pain and swelling by the end of the shift.

According to clinical note dated 10/10/11, the employee continued with a chief complaint of right wrist pain with popping and swelling and erythema. Upon physical examination of the right wrist and hand revealed the employee to be guarded

significantly. The note reported that the employee did have some edema. The employee was reported to have hyperhidrosis and hyperemia consistent with reflex sympathetic dystrophy. The employee had some popping with Watson's maneuver and mild carpal type instability, which was consistent on the opposite side. There was pain over the triangular fibrocartilage with direct palpation. The employee had some pain over his extensor carpi ulnaris tendon.

According to prior review dated for 10/26/11, reported that the employee was denied a right wrist radial stellate ganglion injection due to an unclear indication that the employee had tried to and failed to improve with less invasive modalities of a conventional treatment. The review also reported that there was no formal plan of physical therapy being rendered concurrent to the requested injection.

A prior review dated for 11/03/11, reported that the employee was denied due to no objective documentation of exhaustion of conservative therapies such as oral pharmacotherapy and physical therapy. There was lack of plans of active rehabilitation activities in conjunction with the requested injection.

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

The employee, who reported right wrist pain with popping and swelling and erythema reported that he was working on location at an oil field and was very busy and stated that he had significant pain and swelling by the end of the shift.

The prior review reported that a right wrist radial stellate ganglion injection was denied due to lack of no objective documentation of exhaustion of recommended conservative therapy such as oral pharmacotherapy and physical therapy, and there is lack of evidence that a formal plan of physical therapy was being rendered concurrent to the requested injection. This reviewer agrees with the denial of the right wrist radial stellate ganglion injection, due to the continuation of lack of evidence that the employee has exhausted all lower levels of conservative treatments to include pharmacotherapy or physical therapy. The clinical documentation also lacks evidence that the employee has signs and symptoms of CRPS given that stellate ganglion blocks are generally recommended for therapy for CRPS. Therefore, the right wrist radial stellate ganglion injection is non-certified.

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

Official Disability Guidelines, Pain Chapter, Online Version.

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

Recommendations are generally limited to diagnosis and therapy for CRPS. See CRPS, sympathetic and epidural blocks for specific recommendations for treatment. Also see CRPS, diagnostic criteria; CRPS, medications; & CRPS.

Stellate ganglion block (SGB) (Cervicothoracic sympathetic block): There is limited evidence to support this procedure, with most studies reported being case studies. The one prospective double-blind study (of CRPS) was limited to 4 subjects. Anatomy: Sympathetic flow to the head, neck and most of the upper extremities is derived from the upper five to seven thoracic spinal segments. The stellate ganglion is formed by a fusion of the inferior and first thoracic sympathetic ganglia in 80% of patients. In the other 20%, the first thoracic ganglion is labeled the stellate ganglion. The upper extremity may also be innervated by branches for Kuntz's nerves, which may explain inadequate relief of sympathetic related pain. Proposed Indications: This block is proposed for the diagnosis and treatment of sympathetic pain involving the face, head, neck, and upper extremities. Pain: CRPS; Herpes Zoster and post-herpetic neuralgia; Frostbite. Circulatory insufficiency: Traumatic/embolic occlusion; Post-reimplantation; Post-embolic vasospasm; Raynaud's disease; Vasculitis; Scleroderma. 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. Complications: Incidental recurrent laryngeal nerve block or superior laryngeal nerve block, resulting in hoarseness and subjective shortness of breathe; Brachial plexus block; Intravascular injection; Intrathecal, subdural or epidural injection; Puncture of the pleura with pneumothorax; Bleeding and hematoma. There appears to be a positive correlation between efficacy and how soon therapy is initiated (as studied in patients with CRPS of the hand). Duration of symptoms greater than 16 weeks before the initial SGB and/or a decrease in skin perfusion of 22% between the normal and affected hands adversely affected the efficacy of SGB therapy. (Ackerman, 2006) (Sayson, 2004) (Grabow, 2005) (Colorado, 2006) (Price, 1998) (Day, 2008) (Nader, 2005) See also Stellate ganglion block.

Thoracic Sympathetic Blocks: Not recommended due to a lack of literature to support effectiveness. Utilized for sympathetic blocks of the upper extremity in the 20% of individuals with innervation of the upper extremity by Kuntz's nerves (nerves from the 2nd and 3rd thoracic sympathetic ganglia bypass the stellate ganglion and directly join the brachial plexus). Proposed Indications: CRPS, peripheral neuropathy, brachial plexalgia, sympathetically maintained pain and vascular disorders. (Day, 2008) Complications: neuraxial injection; intravascular injection; nerve injury; pneuemothorax.

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. (Day, 2008) (Sayson, 2004) (Nader, 2005)