

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** April 29, 2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

2<sup>nd</sup> Stellate Ganglion Block to Include CPT Code 64510

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

The reviewer is certified by the American Board of Anesthesiology with a secondary practice in Pain Management with over 40 years of experience.

**REVIEW OUTCOME:**

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

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:**

04/19/12: Office Visit by with Pain Management  
04/23/12: Office Visit by with Pain Management  
10/12/12: Notice of Disputed Issue(s) and Refusal to Pay Benefits  
10/19/12: Office Visit by MD with Pain Management  
12/04/12: Office Visit by MD  
12/13/12: Operative Report by, MD with Pain Center, LLC  
12/24/12: Office Visit by, MD  
01/04/13: Office Visit by, MD with Ortho  
01/04/13: UR performed by DO  
01/08/13: Notice of Disputed Issue(s) and Refusal to Pay Benefits  
01/09/13: Designated Doctor Evaluation by MD with Medical Management Solutions  
02/18/13: UR performed by, MD

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who felt pain in her ring and middle finger when she was loading mild crates into the milk cooler while working and hurt her hand on xx/xx/xx.

10/19/12: The claimant was evaluated by MD for left arm pain. It was noted that she had a chronic history of left arm pain. The pain was noted to be constant, burning, shooting, and aching with allodynia and hypersensitivity. The pain was worse with physical activity and relieved some with rest. On physical exam, she had localized tenderness in the hands. Backward extension was painful. The patient had skin allodynia and hypersensitivity. There was minimal swelling of the upper extremities. DIAGNOSIS: Complex regional pain syndrome. PLAN: Recommend stellate ganglion block.

12/04/12: The claimant was evaluated by MD for finger pain (left hand). She was being treated for a sprain of the long and ring fingers with CRPS. It was noted that she had been referred to pain specialist for blocks but they were not approved. She rated her pain as 1/10. She had a splint for the long and ring fingers, which improved extension. However, the fingers gradually contracted into flexion shortly after the splints were removed. It was located in the left middle finger and in the left ring finger. Medications included Lyrica. It was noted that she had decreased range of motion with ring and long finger extension, numbness only when wearing the wireform extension splint, stiffness, and swelling. On exam, her left fingers/thumb revealed no erythema, ecchymosis, abrasion, rash, lacerations, folliculitis, or temperature difference. The long finger had soft tissue swelling. The ring finger had soft tissue swelling. Pain to palpation was 1/10 at the radial/ulnar ring and long finger PIP joints. Long finger motion was slightly decreased. Ring finger motion was normal and pink. Long finger and ring finger had no dorsal, volar, radial, or ulnar instability to the joints. Capillary refill was within normal limits. DIAGNOSIS: Interphalangeal joint hand sprain. Complex regional pain syndrome. PLAN: She still had not had stellate blocks. Still c/o flex tendency of PIP joints.

12/13/12: Operative Report by MD. POSTOPERATIVE DIAGNOSIS: Complex regional pain syndrome of left upper extremity. PROCEDURE: Left stellate ganglion block under fluoroscopy.

12/24/12: The claimant was evaluated by MD. The visit and exam focused only on her low back. A "Patient Comfort Assessment Guide" documented that she complained of swelling in the ring finger and throbbing pain, continuous while in brace.

01/04/13: The claimant was evaluated by MD for finger pain (left hand). It was noted that she had a stellate nerve block on 12/13/12. Her pain rating was 1/10. It was noted that decreased range of motion with ring finger > long finger PIP extension, numbness only when wearing the wireform extension splint, stiffness

and swelling were improving since stellate block. On exam, the long finger had soft tissue swelling slight at the PIP joint. The ring finger had soft tissue swelling at the PIP joint, with slight improvement. Tenderness to palpation of the long finger and ring finger 1/10 at the PIP joint. Range of motion of the long finger was lacking 5-10 degrees from full extension at the PIP joint, but passively correctable to neutral, light fist, lacking 1 cm pulp-to-palm with claw. Ring finger motion was lacking 25 degrees from full extension at the PIP joint, but passively correctable to neutral, light fist, lacking 1 cm pulp-to-palm with claw. PLAN: Slight improvement in swelling s/p initial nerve block, still having flexion tendency at right > long finger PIP joints. Await approval for second stellate block as additional block may have additive effect to improve residual stiffness and swelling.

01/04/13: UR performed by, DO. RATIONALE: I have reviewed the information provided on 03/09/12 DOI. Issues of extent. 12-13-12 Stellate ganglion procedure note reviewed. There is not documentation of response for time of anesthetic. 12-24-12 note does not address response to Stellate ganglion block. The focus is on unrelated chronic back pain x 10 years. There is no patient pain log nor nurse documenting telephone f/u to assess response. There is not information provided to support further blocks.

01/09/13: The claimant was evaluated by MD for a designated doctor evaluation. He concluded that MMI date was 09/20/12 and left 3<sup>rd</sup> and 4<sup>th</sup> fingers range of motion yielded a 1% whole person impairment.

02/18/13: UR performed by, MD. RATIONALE: Review of the case indicates that the patient has a history of CRPS which has been treated with a stellate ganglion block which offered temporary 25-30% relief. The current request is for a second injection. The criteria established by the ODG for consideration of repeat injection is not met. Recommend denial.

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

The previous adverse decisions are upheld. There is insufficient clinical documentation of the effects of the stellate ganglion block performed on 12/13/12. There is no documentation of the clinical condition of the hand and fingers before and afterwards, sympathetic effects of the nerve block, immediate and next day effects on pain, temperature, and color of the skin of the affected area were not documented. The next office visit after the sympathetic nerve block appears to have concentrated on the lower back. This examination did not occur until 11 days after the procedure. The criteria established by the ODG for consideration of one or more repeat injections is not met. Therefore, the request for 2<sup>nd</sup> Stellate Ganglion Block to Include CPT Code 64510 is not medically necessary and is not certified.

**ODG:**

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,
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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. Guanethidine 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](#))

<p>Regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, &amp; lumbar sympathetic block)</p>	<p>Recommendations are generally limited to diagnosis and therapy for CRPS. See <a href="#">CRPS, sympathetic and epidural blocks</a> for specific recommendations for treatment. Also see <a href="#">CRPS, diagnostic criteria</a>; <a href="#">CRPS, medications</a>; &amp; <a href="#">CRPS, Stellate ganglion block (SGB) (Cervicothoracic sympathetic block)</a>: 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. <i>Anatomy</i>: 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. <i>Proposed Indications</i>: 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-replantation; Post-embolic vasospasm; Raynaud's disease; Vasculitis; Scleroderma. <i>Testing for an adequate block</i>: Adequacy of a sympathetic block should be recorded. A Horner's sign (ipsilateral ptosis, miosis, anhidrosis 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. <i>Complications</i>: 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. (<a href="#">Ackerman, 2006</a>) (<a href="#">Sayson, 2004</a>) (<a href="#">Grabow, 2005</a>) (<a href="#">Colorado, 2006</a>) (<a href="#">Price, 1998</a>) (<a href="#">Day, 2008</a>) (<a href="#">Nader, 2005</a>) See also <a href="#">Stellate ganglion block</a>. <i>Thoracic Sympathetic Blocks</i>: 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 2<sup>nd</sup> and 3<sup>rd</sup> thoracic sympathetic ganglia bypass the stellate ganglion and directly join the brachial plexus). <i>Proposed Indications</i>: CRPS, peripheral neuropathy, brachial plexalgia, sympathetically maintained pain and vascular disorders. (<a href="#">Day, 2008</a>) <i>Complications</i>: neuraxial injection; intravascular injection; nerve injury; pneuemothorax. <i>Lumbar Sympathetic Blocks</i>: There is limited evidence to support this procedure, with most studies reported being case studies. <i>Anatomy</i>: Consists of several ganglia between the L1 and L5 vertebra. <i>Proposed Indications</i>: 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. <i>Adjunct therapy</i>: sympathetic therapy should be accompanied by aggressive physical therapy to optimize success. <i>Complications</i>: 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. <i>Adequacy of the block</i>: This should be determined, generally by measure of skin temperature (with an increase</p>
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	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. ( <a href="#">Day, 2008</a> ) ( <a href="#">Sayson, 2004</a> ) ( <a href="#">Nader, 2005</a> )
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**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)**