INDEPENDENT REVIEWERS OF TEXAS, INC.

2150 S. Central Expressway · Suite 200-264 · McKinney, Texas 75070
Office 214-533-2864 Fax 469-219-3349
E-mail: independentreviewers@hotmail.com

07/18/2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: stellate ganglion block right x2 – two weeks apart

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Anesthesiology

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX XX XX whose date of injury is XX. The patient underwent left stellate ganglion block on XX. Follow up note dated XX indicates that the patient is seen in follow up after left lumbar sympathetic block. XX states XX leg definitely got warmer and has had less pain in it since the injection in XX. XX does continue to have overall dysfunction of all four extremities. XX reports having more problems with right arm and to a lesser extent the right leg. XX describes the problem as continued burning pain with feeling cold. On physical examination XX has not decreased XX medication usage, but has not required any increases either. The right upper extremity has some mottling of the hand compared to the left, but both are quite pale and cool to touch. There is slight mottling in the right foot. There is no purple-blue discoloration of the anterior aspect of the feet which has occurred with this patient in the past. Follow up note dated XX indicates that XX legs are doing better overall. On physical examination XX has some mottling of the skin at both feet. There is continued mottling of the skin of the entire arm, right worse than left.

The initial request was non-certified noting that the patient has had two injections; the most recent injection was a left lumbar sympathetic block in XX. The patient

states that the leg got warmer and there was less pain. The patient continues to have pain in the right arm and leg. There are positive findings upon physical examination. The provider is recommending stellate ganglion block x 2. In this case, there is minimal evidence in the submitted documentation of significant objective gains and functional benefit as a result of the previously completed bloc. In addition, there is minimal evidence that the patient is participating in physical therapy or occupational therapy. The denial was upheld on appeal noting that there is no documentation detailing the outcome of the previous blocks. There was documentation that the patient had previous extensive physical therapy treatment, but there was no documentation detailing the outcome from that treatment. There was also no documentation of Budapest (Harden) criteria having been evaluated for and fulfilled to be in accordance with the guideline criteria for CRPS sympathetic blocks.

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

Based on the clinical information provided, the request for stellate ganglion block right x2 XX apart is not recommended as medically necessary, and the previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto for the right upper extremity and right lower extremity submitted for review. The patient's physical examination fails to establish that the Budapest (Harden) criteria have been evaluated for and met in accordance with guidelines. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

IRO REVIEWER REPORT TEMPLATE -WC

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**
- **X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- **X 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)**

Official Disability Guidelines Treatment Index, 23nd edition online, 2018-Pain Chapter updated 07/10/18

CRPS, sympathetic blocks (therapeutic) Recommend local anesthetic sympathetic blocks for limited, select cases, as indicated below. Not recommend IV regional anesthesia blocks.
Recommendations (based on consensus guidelines) for use of sympathetic blocks (diagnostic block recommendations are included here, as well as in CRPS, diagnostic tests):

(1) There should be evidence that all other diagnoses have been ruled out before consideration of use.

(2) There should be evidence that the Budapest (Harden) criteria have been evaluated for and fulfilled.

(3) If a sympathetic block is utilized for diagnosis, there should be evidence that this block fulfills criteria for success including that skin temperature after the block shows sustained increase (≥ 1.5° C and/or an increase in temperature to > 34° C) without evidence of thermal or tactile sensory block. 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. A Horner's sign should be documented for upper extremity blocks. [Successful stellate block would be noted by Horner's syndrome, characterized by miosis (a constricted pupil), ptosis (a weak, droopy eyelid), or anhidrosis (decreased sweating).] The use of sedation with the block can influence results, and this should be documented if utilized. (Krumova, 2011) (Schürmann, 2007)

(4) Therapeutic use of sympathetic blocks is only recommended in cases that have positive response to diagnostic blocks and diagnostic criteria are fulfilled (See #1-3). These blocks are only recommended if there is evidence of lack of response to conservative treatment including pharmacologic therapy and physical rehabilitation.

(5) 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.

(6) 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) is documented to permit participation in physical therapy/ occupational therapy. Sympathetic blocks are not a stand-alone treatment.

(7) There should be evidence that physical or occupational therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase.

(8) In acute exacerbations of patients who have documented evidence of sympathetically medicated pain (see #1-3), 1 to 3 blocks may be required for treatment.

(9) A formal test of the therapeutic blocks should be documented (preferably using skin temperature).

(Burton, 2006) (Stanton-Hicks, 2004) (Stanton-Hicks, 2006) (IRF for RSD or CRPS, 2003) (Colorado, 2006) (Washington, 2002) (Rho, 2002) (Perez, 2010) (van Eijs, 2011)

Local anesthetic sympathetic blocks:

Recommended for limited, select cases, primarily for diagnosis of sympathetically mediated pain and therapeutically as an adjunct to facilitate physical therapy/ functional restoration. When used for therapeutic purposes the procedure is not considered a stand-alone treatment. The role of sympathetic blocks for treatment of CRPS is largely empirical (with a general lack of evidence-based research for support) but can be clinically important in individual cases in which the procedure ameliorates pain and improves function, allowing for a less painful “window of opportunity” for rehabilitation techniques. (Harden, 2013) Use of sympathetic blocks should be balanced against the side effect ratio and evidence of limited response to treatment. See CRPS, diagnostic tests.

IV regional anesthesia: Not recommended due to lack of evidence for use. This procedure is a technique that allows placement of medications directly in the effected extremity but current literature indicates efficacy is poor. (Harden, 2013) There is no role for IV diagnostic blocks with phentolamine or IVRA with guanethidine. Other procedures include IV regional blocks with lidocaine, lidocaine-methyl-prednisolone, droperidol, ketanserin, atropine, bretylium clonidine, and reserpine. If used, there must be evidence that current CRPS criteria have been met and all other diagnoses have been ruled out. Evidence of sympathetically mediated pain should be provided (see the recommendations below). The reason for the necessity of this procedure over-and-above a standard sympathetic block should also be provided. (Perez, 2010) (Harden, 2013) (Tran, 2010) See also CRPS, treatment.

General information on sympathetic procedures

Current literature: A recent study indicated that there was low-quality literature to support this procedure (some evidence of effect, but conclusions were limited by study design, divergent CRPS diagnostic criteria, differing injection techniques and lack of consistent criteria for positive response). Results were inconsistent and/or extrapolation of questionable reliability with inconclusive evidence to recommend for or against the intervention. (Dworkin, 2013) Other studies have found evidence non-conclusive for this procedure or that low-quality evidence showed this procedure was not effective. (O'Connell, 2013) (Tran, 2010) The blocks are thought to be most beneficial when used early in the disease as an adjunct to rehabilitation with physical or occupational therapy. No controlled trials have shown any significant benefit from sympathetic blockade. (Dworkin 2013) (O'Connell, 2013) (Tran, 2010) (van Eijs, 2012) (Perez, 2010) (van Eijs, 2011) (Nelson, 2006) (Varrassi, 2006) (Cepeda, 2005) (Hartrick, 2004) (Grabow, 2005) (Cepeda, 2002) (Forouzanfar, 2002) (Sharma, 2006)

Historical basis for use: The use of sympathetic blocks for diagnostic and therapeutic purposes in the management of CRPS is based on a previous hypothesis concerning the involvement of the sympathetic nervous system in the pathophysiological mechanism of the disease. (van Eijs, 2012) It has been determined that a sympathetic mechanism is only present in a small subset of patients, and less than 1/3 of patients with CRPS are likely to respond to sympathetic blockade. See Sympathetically maintained pain (SMP).

Predictors of response: Researchers have suggested the following are predictors of poor response to blocks: (1) Long duration of symptoms prior to intervention; (2) Elevated anxiety levels; (3) Poor coping skills; (4) Litigation; (5) Allodynia and hypoesthesia. At this time there are no symptoms or signs that predict treatment success. (Hartrick, 2004) (Nelson, 2006) (van Eijs, 2012)

Interpretation of block results: There is a lack of consensus in terms of defining a successful sympathetic block. Based on consensus, a current suggestion of successful block is one that demonstrates an adequate and sustained increase in skin temperature (≥ 1.5° C and/or an increase in temperature to > 34° C) without evidence of thermal or tactile sensory block. A Horner's sign is should be documented for upper extremity blocks.