

Case Number:	CM14-0104560		
Date Assigned:	07/30/2014	Date of Injury:	11/11/2013
Decision Date:	10/14/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/07/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Internal Medicine, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 47-year-old female who reported an injury on 11/11/2013. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of CRPS, tenosynovitis of the wrist, tenosynovitis of the elbow, and sprain/strain unspecified site of the elbow and forearm. Past medical treatment consisted of physical therapy, acupuncture, and medication therapy. Medications included Gralise, Norco, and Terocin patches. On 06/25/2014, the injured worker complained of hand and wrist pain. The physical examination revealed that the injured worker's motor strength was grossly normal except for right elbow flexion, wrist flexion, wrist extension, PIP, and DIP strength was 3-/5. Sensation of the upper extremities was intact except for a decrease to light touch palpation in the median distribution. On examination of the right wrist and hand, the injured worker had hyperplasia to light touch. There was limited motion of the PIP and the DIP joint on the right hand. The injured worker had decreased grip strength. The treatment plan was for the injured worker to continue the use of Terocin patches and undergo a right stellate ganglion block under fluoroscopy and anesthesia. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Terocin 4% patch #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine (Terocin) Page(s): 112.

Decision rationale: The request for Terocin patch is not medically necessary. The California MTUS Guidelines state that Lidocaine is a transdermal application that is recommended for neuropathic pain and recommended localized peripheral pain after there has been evidence of trial of first line therapy, such as tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica. No other commercially-approved topical formulations of Lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. Nondermal patch formulations are generally indicated as local anesthetics and antipruritic. In 02/2007, the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical Lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Only FDA approved products are currently recommended. The guidelines state that Lidocaine is recommended for localized peripheral pain; however, there was no documentation submitted in the report that the injured worker had such pain. The submitted documentation also did not indicate what the injured worker's pain levels were before, during, and after the application of the Terocin patch. Furthermore, there was no evidence submitted in the report showing that the injured worker had tried and failed any first line therapy. The efficacy of the medication was not provided to support the continuation and the request as submitted did not include a frequency or duration of the medication. As such, the request for Terocin patches is not medically necessary.

Right Stellate Ganglion Block x2, under Fluoroscopy & Anesthesia: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Stellate ganglion block (SGB)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, & lumbarSymp).

Decision rationale: The request for a right stellate ganglion block under fluoroscopy and anesthesia is not medically necessary. The California MTUS Guidelines state that recommendations for stellate ganglion blocks are generally limited to diagnosis and therapy for CRPS. The guidelines state that there is limited evidence to support this procedure, with most studies reported as being case studies. This style of block is proposed for the diagnosis and treatment of sympathetic pain involving the face, head, neck, and upper extremities. It was noted in the submitted documentation that the injured worker had undergone a ganglion block. The efficacy of the previous ganglion block was not submitted for review. The submitted documentation also did not indicate that the injured worker had been participating in any physical therapy as an adjunctive treatment. Given the above, and the lack of evidence submitted for review, the decision for a right stellate ganglion block is not warranted. As such, the request is not medically necessary.

