

<b>Case Number:</b>	CM14-0054587		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	06/30/2011
<b>Decision Date:</b>	11/17/2014	<b>UR Denial Date:</b>	04/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/23/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 patient is a 34-year-old female with a date of injury of 06/30/2011. The listed diagnoses per [REDACTED] are: 1. Reflex sympathetic dystrophy of upper limb. 2. Hand pain. 3. Right wrist TFCC tear, status post arthroscopic surgery x2. According to progress report 03/27/2014, the patient presents with continued pain over the right wrist with radiation to the right upper extremity with numbness, tingling, and weakness. The patient reported hypersensitivity and cold in the right hand. The patient rates pain as 6/10 on a pain scale. Examination of the upper extremity revealed 5/5 motor strength. The right upper extremity hand grip was noted as 4/5. Sensation was normal to light touch, pinprick, and temperature along the dermatomes of the right upper extremity, but there was numbness in all dermatomes of the right hand. The physician is requesting Dendracin cream #3 and series of 3 right stellate ganglion block injections under fluoroscopic guidance. Utilization review denied the request on 04/08/2014. Treatment reports from 04/19/2013 through 04/25/2014 were reviewed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Series of 3 Right Stellate Ganglion Block Injections under fluoroscopic guidance (1 week apart):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** This patient presents with continued pain located in the right wrist with radiation to the upper extremity with tingling, numbness and weakness. The physician is requesting a series of 3 right stellate ganglion block injections under fluoroscopic guidance. The physician states the injections are to be 1-week apart from each other. Regarding stellate ganglion block, the MTUS Guidelines page 103 states that there is limited evidence to support this procedure, but is proposed for the diagnosis and treatment of sympathetic pain involving the face, head, neck, and upper extremities. Utilization review denied the request stating that the requested blocks are not prescribed in conjunction with aggressive rehabilitation program. The MTUS Guidelines page 39 further states that there are no discussions regarding how many injections are to be done, but does emphasize that it has a limited role, for diagnosis primarily and as an adjunct to facilitate physical therapy. In this case, the requested 3 injections are not supported by guidelines. Moreover, there is no clear diagnosis of CRPS. Sensation is noted to be intact other than numbness. No motor deficits are noted; no hypersensitivity; no dystrophic or skin discoloration, the hallmarks of CRPS findings. The request is considered not medically necessary.

**Dendracin Cream #3:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical creams, medication for chronic pain Page(s): 111,60.

**Decision rationale:** TThis patient presents with continued pain in the right wrist with radiation to the upper extremity with tingling, numbness, and weakness. The physician is requesting Dendracin cream #3. Dendracin lotion is a compound topical cream that includes methyl salicylate 30%, capsaicin 0.025%, and menthol 10%. The MTUS Guidelines page 111 has the following regarding topical creams, "Topical analgesics are largely experimental and used with few randomized controlled trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended." In this case, the patient appears to have the indication for the use of topical NSAID and Capsaicin given the patient's wrist condition. However, the physician does not discuss how this compounded product is used with what efficacy. MTUS page 60 require documentation of pain and function when medication is used for chronic pain. The request is not medically necessary.