MAXIMUS Federal Services

Case Number:	CM15-0208047		
Date Assigned:	10/26/2015	Date of Injury:	07/14/2014
Decision Date:	12/08/2015	UR Denial Date:	10/13/2015
Priority:	Standard	Application Received:	10/22/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Washington, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 41 year old female who sustained an industrial injury on 7-14-14. Medical records indicate that the injured worker is undergoing treatment for probable right thoracic outlet syndrome, right cervical and thoracic sprain, right ulnar humeral capsulitis and probable right upper extremity complex regional pain syndrome. The injured worker is currently not working. Treatment to date has included steroid injections into shoulder and neck, medications, acupuncture and physical therapy (15 sessions). Cervical MRI in Oct 2014 showed early degerative changes at C3-7 and right shoulder MRI in Oct 2014 showed tendinosis of supraspinatus and subscapularis tendons. An electromyography-nerve conduction (EMG/NCV) study in Dec 2014 was noted to be normal. Current medications include Lidoderm patches (new prescription), Tramadol and Gabapentin. On 9-15-15 the injured worker complained of right shoulder and neck pain. Most of the pain was over the lateral aspect of the right shoulder and radiated into the lateral aspect of the arm and forearm and into the right side of the face and left occipital area from her neck. Objective findings revealed right shoulder hyperalgesia with allodynia over the right posterior more than anterior glenohumeral joint. Range of motion was decreased with guarding. Cervical spine examination revealed right C5-7 allodynia with referral into the right side of the face. Deep tendon reflexes were 2-4 throughout the bilateral upper extremities. Cervical range of motion was decreased and painful. Right upper extremity examination revealed lateral wrist pain, spasticity over the flexor forearm and moderate allodynia over the thumb. Range of motion was full. Mild to moderate pain was noted over the medial epicondyle more than lateral epicondyle. The current treatment request is for Lidoderm

patches 5% and sympathetic blocks # 6. The Utilization Review documentation dated 10-13-15 non-certified the requests for Lidoderm patches 5% and sympathetic blocks # 6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patches 5% (unspecified quantity): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Lidoderm (lidocaine patch), Topical Analgesics.

Decision rationale: Lidoderm (lidocaine) patch is an anesthetic product formulated for topical use. The use of topical agents to control pain is considered by the MTUS to be an option although it is considered largely experimental, as there is little to no research to support their use. Topical lidocaine in the form of Lidoderm is recommended in the MTUS only for treatment of neuropathic pain. Other topical forms of this medication are not recommended and use of this medication for non-neuropathic pain is also not recommended. Since this patient does not have neuropathic pain use of lidocaine is not recommended. Medically necessary has not been established.

Sympathetic blocks Qty: 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, & lumbar sympathetic block).

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Summary, and Chronic Pain Medical Treatment 2009, Section(s): Complex Regional Pain Syndrome (CRPS), Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic)/CRPS, sympathetic blocks (therapeutic) and Other Medical Treatment Guidelines American Society of Interventional Pain Physicians: Comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. 2) American Society of Interventional Pain Physicians: Official Comments on the ACOEM Guidelines.

Decision rationale: A sympathetic block is an injection of local anesthetic into or around the sympathetic nerves. Sympathetic blocks can be regional (stellate ganglion block, thoracic sympathetic block, & lumbar sympathetic block) or intravenous (IV). The MTUS guidelines and the Official Disability Guidelines (ODG) view regional sympathetic blocks as an option for treating Chronic Regional Pain Syndrome (CRPS) but only in a limited role for diagnosis of sympathetically mediated pain or to facilitate physical therapy as there is only low quality evidence to support this therapy. American Society of Interventional Pain Physicians, however,

recommend regional sympathetic blocks be approved for treatment of chronic pain when there is significant improvement from a prior block. IV regional sympathetic blocks for CRPS are not recommended as there is little evidence for their use. This patient has CRPS. At this point in the care of this patient a sympathetic block for diagnostic purposes would be indicated. However, the provider has requested six such injections. Multiple sympathetic blocks without reassessment of the effectiveness after the initial injection is not supported by any of the guidelines listed above. Medical necessity for the quantity of sympathetic blocks has not been established.