

Case Number:	CM14-0141183		
Date Assigned:	09/10/2014	Date of Injury:	05/01/1985
Decision Date:	10/17/2014	UR Denial Date:	08/11/2014
Priority:	Standard	Application Received:	09/02/2014

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 Pain Medicine and is licensed to practice in Texas and Ohio. 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 69-year-old female who reported an injury on 05/01/1985. The mechanism of injury was not provided. On 01/14/2014, the injured worker presented with chronic migraines. Current medications included Fentanyl, Ambien, Percocet, and Prozac. Upon examination, there was no evidence of sensory loss. There is normal sensation to pinprick in the upper and lower extremities. There were 2+ deep tendon reflexes bilaterally in the upper and lower extremities. Diagnoses were stenosis of the lumbar spine, failed back surgery syndrome, reflex sympathetic dystrophy of the upper limb, reflex sympathetic dystrophy of the lower limb, and lumbar radiculopathy. The provider recommended a right ganglion block and Fentanyl. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl 50mcg/hr Patches, #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl Page(s): 44, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl Transdermal System), Page(s): 44.

Decision rationale: The request for fentanyl 50 mcg/hour patches x 10 is not medically necessary. The California MTUS Guidelines state that fentanyl patches are "not recommended as a first line therapy." FDA approved product labeling states that "Duragesic, or fentanyl, is indicated in management of chronic pain in injured workers who require continuous opioid analgesia for pain that cannot be managed by other means." There is lack of documentation of objective functional improvement with prior use of the medication. Additionally, efficacy of the prior use of the medication has not been provided. As such, medical necessity has not been established; therefore, the request for Fentanyl 50mcg/hr Patches, #10 is not medically necessary.

Fentanyl 75mcg/hr, #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl Page(s): 44, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system), Page(s): 44.

Decision rationale: The request for fentanyl 75 mcg/hour patches x 10 is not medically necessary. The California MTUS Guidelines state that "fentanyl patches are not recommended as a first line therapy." FDA approved product labeling states that "Duragesic, or fentanyl, is indicated in management of chronic pain in injured workers who require continuous opioid analgesia for pain that cannot be managed by other means." There is lack of documentation of objective functional improvement with prior use of the medication. Additionally, efficacy of the prior use of the medication has not been provided. As such, medical necessity has not been established; therefore, the request for Fentanyl 75mcg/hr, #10.

Stellate ganglion block, right with fluoroscopic guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Stellate ganglion blocks Page(s): 103.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regional Sympathetic Block (Stellate Ganglion Block, Thoracic Sympathetic Block, and Lumbar Symp.

Decision rationale: The request for a stellate ganglion block, right, with fluoroscopic guidance is not medically necessary. California MTUS states that the recommendations for a stellate ganglion block are generally limited to diagnoses of therapy for CRPS. There is limited evidence to support the procedure with most studies reported being case studies. There should be symptom duration of greater than 16 weeks before the initial stellate ganglion block and/or a decrease in skin perfusion of 22% between the normal and affected hands adversely affected. The injured worker does not have a diagnosis congruent with the guideline recommendation for a stellate ganglion block. In addition, there is lack of objective functional deficits provided, as well as an adequate and complete pain assessment of the injured worker. As such, medical necessity has not

been established; therefore, the request for Stellate Ganglion Block, Right with Fluoroscopic Guidance is not medically necessary.

Anesthesia for Stellate ganglion block (SGB): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Stellate ganglion blocks Page(s): 103.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

X-rays with Stellate Ganglion Block (SGB) Fluoroscopic Guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Stellate ganglion blocks Page(s): 103.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.