

<b>Case Number:</b>	CM14-0017716		
<b>Date Assigned:</b>	04/16/2014	<b>Date of Injury:</b>	10/14/1998
<b>Decision Date:</b>	09/03/2014	<b>UR Denial Date:</b>	01/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2014

### 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 Anesthesiology, has a subspecialty in Acupuncture and Pain Management, 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 43-year-old with date of injury October 14, 1996 with related bilateral neck and shoulder, midline spine from cervical spine through lumbar, left gluteal and lateral upper thigh pain. Per progress report dated January 7, 2014, she described her pain as 10/10 at worst, 5/10 on average. Associated symptoms included numbness in both arms and hands while laying down, left arm when sitting and driving, stiffness and decreased ROM (range of motion) in both shoulders. MRI of the cervical spine dated April 8, 2013 revealed large central disc protrusion at C4-C5 with extruded fragment, the protrusion flattens the spinal cord resulting in severe stenosis. She was refractory to physical therapy and medication management. The date of UR decision was January 28, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **BILATERAL C3, C4 AND C5 FACET NERVE BLOCKS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES ODG-REGARDING FACET BLCOKS.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Facet Joint Diagnostic Blocks.

**Decision rationale:** According to the ODG, facet joint diagnostic blocks are recommended prior to facet neurotomy (a procedure that is considered "under study"). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT [physical therapy] and NSAIDs [non-steroidal anti-inflammatory drugs]) prior to the procedure for at least four to six weeks. 4. No more than two joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for four to six hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. 12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. According to the MRI of the cervical spine dated April 8, 2013, severe stenosis of the spinal cord was noted at C4-C5. Additionally, the injured worker presented clinically with numbness in the bilateral arms. These findings are consistent with radiculopathy, which is a disqualifying criteria for the procedure. Furthermore, the request is for three joint levels, and the guidelines recommend no more than two levels injected in one session. The request for Bilateral C3, C4 and C5 facet nerve blocks is not medically necessary or appropriate.

**Prescription of Norco 10/325 mg, 150 count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS FOR CHRONIC PAIN.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 91.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines regarding ongoing management of opioids "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. These domains have been summarized as the '4 As' (Analgesia, activities of

daily living, adverse side effects, and any aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." Review of the available medical records reveals no documentation to support the medical necessity of norco nor any documentation addressing the '4 A's' domains, which is a recommended practice for the on-going management of opioids. Specifically, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The Chronic Pain Medical Treatment Guidelines considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Furthermore, efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. There is no documentation comprehensively addressing this concern in the records available for my review. As the Chronic Pain Medical Treatment Guidelines recommends to discontinue opioids if there is no overall improvement in function, medical necessity cannot be affirmed. The request for Prescription of Norco 10/325 mg, 150 count is not medically necessary or appropriate.

**Prescription of Lyrica 75 mg, sixty count:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-EPILEPSY DRUGS (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16-17, 99.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, "Pregabalin (Lyrica) has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. Pregabalin was also approved to treat fibromyalgia." Pregabalin is the prodrug of gabapentin and is often used when gabapentin is clinically not sufficiently effective. According to the Chronic Pain Medical Treatment Guidelines, "Gabapentin (Neurontin) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." As the injured worker clinically presents with numbness in both arms, and has evidence of spinal cord stenosis, the request for a prescription of Lyrica 75mg, sixty count, is medically necessary and appropriate.