

Case Number:	CM14-0180890		
Date Assigned:	11/04/2014	Date of Injury:	05/25/2000
Decision Date:	12/11/2014	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	10/29/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 60-year-old woman who sustained a work-related injury on May 25, 2000. Subsequently, she developed chronic neck pain. Past medical treatment included medications (Norco, effexor, Lyrica, Prilosec, Senna), chiropractic therapy, physical therapy, acupuncture, and epidural steroid injections. In addition, the patient had an ILESI of C5-6 on April 18, 2014 and reported minimal benefit from this procedure. An MRI of the thoracic spine, performed on January 9, 2014, showed mild degenerative disc disease without spondylolisthesis, compression deformity, significant focal protrusion, canal stenosis, and neural foraminal narrowing. According to a progress report dated October 20, 2014, the patient complained of neck, mid back, and low back pain. The patient rated her pain at 8-9/10 with medication and 10/10 without medication. She reported radiation of pain, numbness, tingling, and weakness in both arms down to her hands. She further described bilateral elbow pain, both medial and lateral aspects. The patient complained of constipation and GI discomfort associated with medications use. On examination, the patient had slow and antalgic gait. She had diffuse palpation tenderness in her cervical, thoracic, and lumbar paraspinous regions. There was decreased range of motion in all planes of the cervical and lumbar spines, limited by pain in all planes. The upper extremity and lower extremity sensation was intact. Deltoid, biceps, internal rotators, and external rotators were 4+/5 on the left. Tibialis anterior, EHL, inversion, eversion, and plantarflexors were 4+/5 bilaterally. Psoas, quadriceps, and hamstrings were 5-/5 bilaterally. Straight leg raising was positive bilaterally at 80 degrees eliciting pain to the foot. The UDS dated July 28, 2013 was consistent. The patient was diagnosed with cervical pain/strain with possible radiculopathy, bilateral carpal tunnel syndrome, left shoulder subacromial bursitis, canal stenosis C5-6, cervicogenic versus neurogenic headaches, and chronic mid and low back pain. The provider

request authorization for Medial branch block targeting bilateral C4-5 and C5-6 facet, Hydrocodone/APAP, and Venlafaxine ER.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial branch block targeting bilateral C4-5 and C5-6 facets: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183. Decision based on Non-MTUS Citation ODG, Neck and Upper Back Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Facet joint intra-articular injections (therapeutic blocks)
(http://worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#Facetjointinjections)

Decision rationale: According MTUS guidelines, Invasive techniques (e.g., local injections and facet-joint injections of cortisone and Lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain. According to ODG guidelines regarding facets injections, under study. Current evidence is conflicting as to this procedure and at this time, no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent Neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti , 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial. Furthermore and according to ODG guidelines, Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. If successful (initial pain relief of 70%, and pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent Neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time. 5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. The ODG guidelines did not support facet injection for cervical pain in this context. There is no strong evidence supporting the use of cervical facet injection for the treatment of neck pain. There is no

documentation that the cervical facets are the main pain generator. There is no documentation of formal rehabilitation plan that will be used in addition to facet injections. Furthermore, there is no documentation of rationale behind the request for cervical facet block and whether this is used for diagnostic and therapeutic purpose. Therefore, the request for Medial branch block targeting bilateral C4-5 and C5-6 facets is not medically necessary.

Hydrocodone/APAP 10/325mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 179.

Decision rationale: According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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 non adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework>.There is no clear justification for the need to continue the use of Hydrocodone. The patient was treated with Hydrocodone without any evidence of pain and functional improvement. In addition, the patient has developed constipation and GI discomfort associated with medication use. Therefore, the prescription of Hydrocodone/APAP tab 10/325mg is not medically necessary.

Venlafaxine ER 37.5mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Effexor Page(s): 124.

Decision rationale: According to MTUS guidelines, < Effexor is recommended as an option in first-line treatment of neuropathic pain. Venlafaxine (Effexor) is a member of the selective-serotonin and norepinephrine reuptake inhibitor (SNRIs) class of antidepressants. It has FDA approval for treatment of depression and anxiety disorders. It is off label recommended for treatment of neuropathic pain, diabetic neuropathy, fibromyalgia, and headaches. The initial dose is generally 37.5 to 75 mg/day with a usual increase to a dose of 75 mg b.i.d or 150 mg/day of the ER formula. The maximum dose of the immediate release formulation is 375 mg/day and of

the ER formula is 225 mg/day>. Effexor is generally considered after failure of tricyclic antidepressants or if they are poorly tolerated or contraindicated for treatment of chronic pain. Although the patient developed a chronic pain syndrome and depression, there is no clear rationale for using Effexor. There is no documentation of failure, intolerance or contraindication for using first line antidepressors. There is no documentation of the medical necessity to use Effexor and the modalities to assess its efficacy and side effects. Therefore, the request for Venlafaxine ER 37.5 mg #60 is not medically necessary.