

<b>Case Number:</b>	CM14-0192279		
<b>Date Assigned:</b>	12/01/2014	<b>Date of Injury:</b>	06/05/2007
<b>Decision Date:</b>	03/10/2015	<b>UR Denial Date:</b>	11/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2014

### 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. 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: 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:

Patient is a 47 year-old male with date of injury 06/05/2007. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 10/08/2014, lists subjective complaints as chronic pain in the neck and bilateral upper extremities. Patient reported that his medications were wearing off too fast. Objective findings: Examination of the cervical spine revealed no tenderness, crepitation or deformity on palpation. Movement was mildly restricted in all directions, lateral rotation on the left was moderately restricted, and extension severely restricted. Examination of the bilateral upper extremities revealed normal muscle strength and no muscle or joint tenderness to palpation. No crepitation or fasciculations. Muscle strength was 5/5 bilaterally. No neurological findings were documented. No Diagnosis were found in the medical records supplied for review. It was stated in the medical records supplied for review that the patient has had previous treatments of occipital nerve blocks and cervical facet blocks, but no other specific information regarding the treatment was provided. It was noted by the requesting provider that the patient had been prescribed the following medications before the request for authorization on 10/08/2014, but the medical records supplied for review were insufficient to be able to determine exact time frames for use. Medication: 1. Venlafaxine 75mg SIG: po daily 2. Gabapentin 600mg SIG: TID 3. Voltaren Gel SIG: topical 4. Namenda 10mg SIG: po daily 5. Liquid Vicoden 7.5/325mg SIG: po q6h 6. Butrans Patch 10mcg/hr.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Genetic Testing for CYP450 C2D6: 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 9792.20 - 9792.26 Page(s): 42.

**Decision rationale:** There is currently no evidence-based, peer-reviewed guidelines recommending genetic testing to determine hereditary predisposition to the addiction of narcotics. There is currently no evidence-based guideline supporting that the knowledge of a patient's genetic propensity to addiction would change or guide the treatment in any way. A similar situation using cytokine DNA testing for pain is referenced in the MTUS Chronic Pain guidelines and is not recommended. Genetic Testing for CYP450 C2D6 is not medically necessary.

**Ultrasound Guided Occipital Nerve Block: Upheld**

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

**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 (Acute & Chronic), Greater occipital nerve block, therapeutic.

**Decision rationale:** The Official Disability Guidelines state that there is little evidence that greater occipital nerve blocks provide sustained relief of occipital neuralgia or cervicogenic headaches. It was stated in the medical records supplied for review that the patient has had previous treatments of occipital nerve blocks and cervical facet blocks, but no other specific information regarding the treatment was provided. There is no documentation of functional improvement. Ultrasound Guided Occipital Nerve Block is not medically necessary.

**Cervical Facet MBB: Upheld**

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

**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 (Acute & Chronic), Facet joint therapeutic steroid injections.

**Decision rationale:** The Official Disability Guidelines state that facet joint therapeutic steroid injections are not recommended. A medial branch block is generally considered a diagnostic block and has been used occasionally with patients who may undergo a surgical procedure. The

ODG states clearly that the use of therapeutic intra-articular and median branch blocks is not recommended, but if used anyway, several criteria need to be met and the clinical presentation should be consistent with facet joint pain, signs, and symptoms. The medical record fails to document the criteria necessary for consideration of a therapeutic block. Cervical Facet MBB is not medically necessary.

**Venlafaxine 75mg po daily:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Venlafaxine Effexor.

**Decision rationale:** Recommended as an option in first-line treatment of neuropathic pain. Venlafaxine (Effexor) is a member of the selective serotonin and norepinephrine reuptake inhibitors (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 patient suffers from headaches. I am reversing the previous utilization review decision. Venlafaxine is medically necessary.

**Gabapentin 600mg po TID:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 19.

**Decision rationale:** The MTUS states that gabapentin is an anti-epilepsy drug which 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. An adequate trial period for gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. With each office visit the patient should be asked if there has been a change in the patient's pain symptoms, with the recommended change being at least 30%. There is no documentation of any functional improvement. Gabapentin 600mg po TID is not medically necessary.

**Voltaren Gel:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Voltaren® Gel diclofenac.

**Decision rationale:** According to the Official Disability Guidelines, Voltaren gel is not recommended as a first as a first-line treatment, and is recommended only for osteoarthritis after failure of oral NSAIDs, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. Documentation in the medical record does not meet guideline criteria. Voltaren Gel is not medically necessary.

**Namenda 10mg po daily:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Namenda Full Prescribing Information, Forest Pharmaceuticals, Inc., Subsidiary of Forest Laboratories, Inc., St. Louis, MO 63045.

**Decision rationale:** Memantine (Namenda) treats dementia (memory loss and mental changes) that is a sign of Alzheimer's disease. The MTUS and Official Disability Guidelines are silent on the use of an Alzheimer's drug in the treatment of a worker's compensation injury. Namenda Full Prescribing Information was referenced as an alternative. The medical record contains no documentation that the patient suffers from any work-related dementia or from Alzheimer's disease. There appears to be no clinical indication warranting the use of Namenda at this time. Namenda is not medically necessary.

**Liquid Vicodin 7.5/325mg po q 6 hours:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 60.

**Decision rationale:** According to the MTUS in regard to medications for chronic pain, only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. A record of pain and function with the medication should be recorded. According to this citation from the MTUS, medications should not be initiated in a group fashion, and specific benefit with respect to pain and function should be documented for each medication. There is no documentation of the above criteria for either of narcotics that the patient has been taking, Butrans or Vicodin. Liquid Vicodin 7.5/325mg po q 6 hours is not medically necessary.

**Butrans Patch 10mcg/Hr:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 74-94.

**Decision rationale:** Butrans is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. The MTUS states that opioids may be continued, (a) If the patient has returned to work, or (b) If the patient has improved functioning and pain. There is no documentation that the patient fits either of these criteria.