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| <b>Case Number:</b>   | CM13-0058349 |                              |            |
| <b>Date Assigned:</b> | 12/30/2013   | <b>Date of Injury:</b>       | 02/01/2007 |
| <b>Decision Date:</b> | 03/24/2014   | <b>UR Denial Date:</b>       | 11/13/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/26/2013 |

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and is licensed to practice in New York State. 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 physician 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 claimant is a 56 yo female who sustained a work injury on 02/01/2007. She developed the injury due to repetitive use of the right hand such as gripping, grasping, and lifting. Her diagnoses include right scaphotrapezoid arthritis s/p right carpometacarpal trapeziectomy and arthroplasty with ligament reconstruction and tendon interposition, right carpal tunnel syndrome-s/p endoscopic carpal tunnel release, neuralgia, sleep disturbance, and complex regional pain syndrome. She has persistent right hand pain which is increased with hand motions, and burning over the dorsal and ventral aspects of her thumb, index finger in the superficial radial distribution and ventral aspect of the hand. She is maintained on medical therapy including opiates and has undergone interventional therapies with surgeries, nerve blocks, chemodenervation and radiofrequency nerve ablation. The treating provider has requested Percocet 10/325mg 1-2/day, Zofran 4mg three times per day, Ambien 5mg at bedtime, and Medrox ointment 120mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Percocet 10/325:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Office of Disability Guidelines (ODG), Work Loss Data Institute chronic Pain Chapter, and ODG Forearm, Wrist and Hand (Acute and Chronic) Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-97.

**Decision rationale:** The documentation indicates the enrollee has been treated with long acting opiate therapy- MS Contin and short acting opioid therapy with Percocet 10/325 1-2 /day. Per California MTUS Guidelines, short-acting opioids such as Percocet are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no specific indication for the use of Percocet in addition to MS Contin. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. Medical necessity for Percocet 10/325 1-2 /day has not been established. The requested treatment is not medically necessary.

**Zofran 4 MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Office of Disability Guidelines (ODG), Work Loss Data Institute chronic Pain Chapter, and ODG Forearm, Wrist and Hand (Acute and Chronic) Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine

**Decision rationale:** Ondansetron, originally marketed under the brand name Zofran, is a serotonin 5-HT<sub>3</sub> receptor antagonist used to prevent nausea and vomiting caused by cancer chemotherapy, radiation therapy, and surgery. The medication is being prescribed to treat the nausea associated with opiate therapy. The nausea and vomiting associated with opiate therapy are usually limited to short term duration ( less than four weeks) and have limited application to long term use. There is no indication for the long term use of Zofran 4mg three times a day in this particular clinical setting. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

**Ambien 5 MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Office of Disability Guidelines (ODG), Work Loss Data Institute chronic Pain Chapter, and ODG Forearm, Wrist and Hand (Acute and Chronic) Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine- Treatment of Insomnia 2012

**Decision rationale:** There is no documentation for this requested medication. The claimant is being weaned off the medication. Gabazolpidem-Zolpidem (Ambien) is a short-acting nonbenzodiazepine hypnotic indicated for the short-term treatment (two to six weeks) for managing insomnia. Long-term use is not recommended as there are associated risks of impaired function and memory with use more than opioids, as well as Ambien may be habit forming. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

**Medrox Ointment 120 Grams:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Office of Disability Guidelines (ODG), Work Loss Data Institute chronic Pain Chapter, and ODG Forearm, Wrist and Hand (Acute and Chronic) Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** There is no documentation provided necessitating use of the requested topical medication, Medrox Ointment. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, gamma agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments There is no documentation of failure to oral medication therapy. The requested treatment is not medically necessary.