

<b>Case Number:</b>	CM15-0207415		
<b>Date Assigned:</b>	10/26/2015	<b>Date of Injury:</b>	08/01/2013
<b>Decision Date:</b>	12/09/2015	<b>UR Denial Date:</b>	09/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2015

### 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:

The injured worker is a 58 year old female, who sustained an industrial injury on 08-01-2013. The injured worker is currently able to work with limitations, but not working. Medical records indicated that the injured worker is undergoing treatment for discogenic cervical condition, epicondylitis, ulnar neuritis, bilateral carpal tunnel syndrome, bilateral wrist inflammation, and bilateral intersection syndrome. Treatment and diagnostics to date has included right wrist injection, cervical spine MRI, use of TENS (Transcutaneous Electrical Nerve Stimulation) Unit, soft and rigid braces, and medications. Recent medications have included Naproxen, Flexeril, Protonix, and Tramadol. Subjective data (08-03-2015 and 09-15-2015), included symptoms involving her neck, left elbow, wrist, and thumb. Objective findings (09-15-2015) included tenderness along the cervical spine with positive facet joint and tenderness along the epicondylar surfaces of the wrist and ulnar aspect of the elbow with positive Tinel's. The request for authorization dated 09-15-2015 requested an injection, Zofran 10mg (#20), Neurontin 600mg (#180), Percocet 5mg (#120), Naproxen, Protonix, Tramadol, Flexeril, Lidoderm patches, a consultation, polar care for 21 day rental, and a sling. The Utilization Review with a decision date of 09-23-2015 denied the request for retrospective postoperative Zofran 10mg #20, retrospective postoperative Neurontin 600mg #180, and retrospective postoperative Percocet 5mg #120.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro post op Zofran 10 mg #20 with a dos of 9/15/2015: 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter/Antiemetics (for opioid nausea) Section.

**Decision rationale:** The MTUS Guidelines do not address the use of ondansetron. The ODG does not recommend the use of antiemetics for nausea and vomiting secondary to chronic opioid use. Ondansetron is FDA approved for use with nausea as a result of chemotherapy or radiation treatments, post-operative nausea, and acutely in gastroenteritis. In this case, there is an approval for left ulnar nerve release from September-2015. However, there is no supporting documentation to provide evidence that the surgery was completed. Without evidence of surgery, the request is not supported. The request for retro post op Zofran 10 mg #20 with a dos of 9/15/2015 is not medically necessary.

**Retro post op Neurontin 600 mg #180 with an rx date of 9/15/2015: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** The MTUS Guidelines recommend the use of antiepilepsy drugs for neuropathic pain. Most randomized controlled trials for the use of antiepilepsy drugs for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy, with polyneuropathy being the most common example. There are few RCTs directed at central pain, and none for painful radiculopathy. A good response to the use of antiepilepsy drugs has been defined as a 50% reduction in pain and a moderate response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response to this magnitude may be the trigger for switching to a different first line agent, or combination therapy if treatment with a single drug fails. After initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of antiepilepsy drugs depends on improved outcomes versus tolerability of adverse effects. 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. In this case, there is an approval for left ulnar nerve release from September-2015. However, there is no supporting documentation to provide evidence that the surgery was completed. Without evidence of surgery, the request is not supported. The request for retro post op Neurontin 600 mg #180 with an rx date of 9/15/2015 is not medically necessary.

**Retro post-op Percocet 5 mg #120 with a dos of 9/15/2015: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. In this case, there is an approval for left ulnar nerve release from September-2015. However, there is no supporting documentation to provide evidence that the surgery was completed. Without evidence of surgery, the request is not supported. The request for retro post-op Percocet 5 mg #120 with a dos of 9/15/2015 is not medically necessary.