

<b>Case Number:</b>	CM15-0109130		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	05/04/2009
<b>Decision Date:</b>	10/20/2015	<b>UR Denial Date:</b>	05/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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: Emergency 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 53 year old female who sustained an industrial injury on 5-4-09. Diagnoses included right wrist pain; triangular fibrocartilage complex tear, status post arthroscopic surgery (2-10-10 and 9-20-10); right cubital tunnel syndrome, status post right ulnar nerve release; complex regional pain syndrome, right upper extremity; chronic pain syndrome. She currently (4-30-15) complains of right arm pain extending to the right side of her neck. Her pain level was 9 out of 10 without medication and 6 out of 10 with medication. Her pain level has remained unchanged with current medication regimen since 5-30-14. She is able to function with pain medication and does some household chores. She has anxiety issues. She has an opioid agreement, does not exhibit aberrant behavior and last urine toxicology test was consistent with pain medications (3-5-15) per 4-30-15 note. On physical exam she was noted to have a weak grip in her right hand, healed surgical scars in the right distal forearm, right wrist and right elbow, Tinel's was positive in the right elbow, limited range of motion of the right wrist with tenderness to palpation and palpable click with movement. She is not working. Treatments to date included stellate ganglion block (8-14-13) without benefit; medications (current): Percocet, Zoloft, Xanax; prior: Lyrica. In the progress note dated 4-30-15 the treating provider's plan of care included requests for Percocet 10mg #120 with no refills. The request for authorization dated 5-1-15 indicates Percocet 10mg #120; Xanax 0.5mg #30 with no refills for anxiety. On 5-8-15 utilization review evaluated and non-certified the requests for Percocet 10mf #120; Xanax 0.5mg #30 based on no documentation of quantifiable objective improvement or attempt to taper medication (Percocet) and no documentation of objective improvement in anxiety with Xanax.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10mg #120:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, long-term assessment.

**Decision rationale:** Percocet is acetaminophen and Oxycodone, an opioid. Patient has chronically been on an opioid pain medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation fails criteria. There is appropriate documentation of benefit from percocet therapy. There is documentation of appropriate monitoring for abuse or side effects. There is a plan for potential weaning once SCS trial is done. Continued percocet is medically necessary.

**Xanax 0.5mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** Xanax is a benzodiazepine. As per MTUS Chronic pain guidelines is not recommended for long term use. There is strong risk of dependence and tolerance develops rapidly. Review of records show that patient is chronically on this medication. The appropriate treatment of anxiety is anti-depressants and other modalities to manage anxiety and depression. The number of tablets is not appropriate for intermittent use only during panic attacks but chronic persistent use. Xanax is not medically necessary.