MAXIMUS Federal Services

| Case Number: | CM14-0182727 | | |
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| Date Assigned: | 11/07/2014 | Date of Injury: | 09/27/2004 |
| Decision Date: | 12/11/2014 | UR Denial Date: | 10/09/2014 |
| Priority: | Standard | Application Received: | 11/03/2014 |

## 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 54-year-old woman who sustained a work-related injury on September 27, 2004. Currently, she developed a chronic neck and back pain. According to a progress report on September 24, 2014, the patient physical examination demonstrated the cervical and lumbar tenderness with reduced range of motion, reduced range of motion of the right knee, tenderness over the thoracic spine and sacral pelvic region, decreased sensation over the L5 and S1 dermatome. The patient lumbar MRI demonstrated the degenerative disc disease with facet arthropathy and bilateral foraminal stenosis. The patient was previously treated with the Vicodin omeprazole and docusate. The patient was also treated with physical therapy, bracing, trigger point injections, psychotherapy and pain medications. The provider requests authorization for Zohydro and epidural steroid injection.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Zohydro ER 10 mg # 30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75-81.

**Decision rationale:** Zohydro ER is an opioid agonist, extended-release, oral formulation of Hydrocodone Bitartrate 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. It is 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.According to the patient file, there is no objective documentation of pain and significant functional improvement to justify continuous use of opioids. The addition of Zohydro another opioids is not clearly justified. There is no clear justification for the use of several narcotics. Therefore, the prescription of Zohydro ER 10 mg # 30 is not medically.

**1 Lumbar Epidural Steroid Injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** According to MTUS guidelines, epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit; however there is no significant long term benefit or reduction for the need of surgery. Furthermore, the patient file does not document that the patient is candidate for surgery. In addition, there is no recent clinical and objective documentation of radiculopathy. There are no MRI or EMG reports supporting the diagnosis of active radiculopathy. MTUS guidelines do not recommend epidural injections for back pain without radiculopathy. Therefore, the request for 1 lumbar epidural steroid injection is not medically necessary.