

<b>Case Number:</b>	CM15-0012742		
<b>Date Assigned:</b>	01/30/2015	<b>Date of Injury:</b>	09/05/2000
<b>Decision Date:</b>	04/03/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/22/2015

### 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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 54 year old female, who sustained an industrial injury on 9/05/2000. The diagnoses have included degeneration of cervical intervertebral disc, carpal tunnel syndrome, degeneration of lumbar intervertebral disc, cervical spinal stenosis, brachial neuritis or radiculitis and major depression. Treatment to date has included medications, restrictions and diagnostic testing. Currently, the IW complains of radicular low back pain and cervical pain as well as bilateral carpal tunnel syndrome. She reports psychiatric stability in response to treatment being provided. Objective findings included a well-dressed, well groomed woman appearing her stated age. She had a cooperative attitude with good eye contact. Mood is euthymic. On 1/15/2015, Utilization Review non-certified a request for Zohydro ER 40mg #120, noting that the clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The MTUS was cited. On 1/22/2015, the injured worker submitted an application for IMR for review of Zohydro ER 40mg #120.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zohydro ER 40mg # 120 with 1 refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids  
Page(s): 79.

**Decision rationale:** Zohydro ER 40 mg #120 with 1 refill is not medically necessary. Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. The claimant has long-term use with opioid medication and there was a lack of improved function. Additionally, Zohydro is a controlled release medication recommended for malignant chronic pain. The patient has benign chronic pain; therefore the requested medication is not medically necessary.