

<b>Case Number:</b>	CM15-0196362		
<b>Date Assigned:</b>	10/12/2015	<b>Date of Injury:</b>	10/16/2001
<b>Decision Date:</b>	11/19/2015	<b>UR Denial Date:</b>	09/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2015

### 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 63 year old male, who sustained an industrial injury on 10-16-01. The injured worker is being treated for chronic low back pain, lumbar fusion L4-S1 with hardware removal and lumbar radiculopathy. Urine drug screen performed on 12-18-14 was consistent with medications prescribed. Treatment to date has included oral medications including Gabapentin and Lyrica (tried and failed), Cymbalta, Tramadol, Zohydro ER, Oxy IR, Lisinopril and Ibuprofen; physical therapy (cannot recall if it was effective). On 8-19-15 and 9-16-15, the injured worker complains of continued low back pain with radiation to right leg and associated with numbness and tingling in thigh; he rates the pain 7-8 out of 10. On 8-19-15, he had not noticed any significant pain relief after starting Zohydro ER. Physical exam performed on 8-19-15 and 9-16-15 revealed moderate bilateral lumbar paraspinal muscle tenderness to palpation, normal range of motion, altered sensation throughout left lower extremity, slight weakness in right ankle plantar flexion and positive straight leg raise bilaterally. The treatment plan included request for titrating of Zohydro ER #60, Oxy IR #120, Ibuprofen 800mg #60, Horizant 600mg #30 and request for authorization for physical therapy 8 sessions. On 9-29-15 request for Zohydro ER #60 was non-certified by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Zohydro ER 20mg #60: 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) Treatment.

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

**Decision rationale:** The requested Zohydro ER 20mg #60, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has continued low back pain with radiation to right leg and associated with numbness and tingling in thigh; he rates the pain 7-8 out of 10. On 8-19-15, he had not noticed any significant pain relief after starting Zohydro ER. Physical exam performed on 8-19-15 and 9-16-15 revealed moderate bilateral lumbar paraspinal muscle tenderness to palpation, normal range of motion, altered sensation throughout left lower extremity, slight weakness in right ankle plantar flexion and positive straight leg raise bilaterally. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Zohydro ER 20mg #60 is not medically necessary.

## **Physical therapy for the lumbar spine, quantity 8: Upheld**

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

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

**Decision rationale:** The requested physical therapy for the lumbar spine, quantity 8, is not medically necessary. CA MTUS 2009, Chronic Pain Medical Treatment Guidelines, Physical Medicine, Page 98-99, recommend continued physical therapy with documented objective evidence of derived functional improvement. The injured worker has continued low back pain with radiation to right leg and associated with numbness and tingling in thigh; he rates the pain 7-8 out of 10. On 8-19-15, he had not noticed any significant pain relief after starting Zohydro ER. Physical exam performed on 8-19-15 and 9-16-15 revealed moderate bilateral lumbar paraspinal muscle tenderness to palpation, normal range of motion, altered sensation throughout left lower extremity, slight weakness in right ankle plantar flexion and positive straight leg raise bilaterally. The treating physician has not documented objective evidence of derived functional improvement from completed physical therapy sessions, nor the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. The criteria noted above not having been met, Physical therapy for the lumbar spine, quantity 8 is not medically necessary.