

Case Number:	CM13-0041252		
Date Assigned:	12/20/2013	Date of Injury:	01/14/1999
Decision Date:	02/12/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	10/11/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Emergency Medicine and is licensed to practice in New York. 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 physician 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 55-year-old female with continuing back pain after being injured on January 14, 1999. The mechanism of injury is not documented. Diagnoses included recurrent disc herniation, chronic low back pain, and degenerative disc and facet disease. MRI done on February 14, 2011 was read as multilevel disc bulges and facet arthrosis. Treatment included medications, epidural injections, spinal stimulator and multiple spinal surgeries. Requests for retrospective authorization for morphine sulfate and prospective authorization for morphine sulfate were submitted on October 1, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective medication request Morphine Sulfate: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment

plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDS have failed. Opioids are considered a second-line treatment for several reasons: (1) head-to-head comparisons have found that opioids produce more side effects than TCAs and gabapentin; (2) long-term safety has not been systematically studied; (3) long-term use may result in immunological and endocrine problems (including hypogonadism); (4) treatment may be associated with hyperalgesia; & (5) opioid use is associated with misuse/abuse. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. In this case the medication was not prescribed for short term use and the criteria for opioid use were not met. Furthermore the recommendation is that dosing does not exceed 120 mg oral morphine equivalents per day, and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. In this case the patient takes 320 long-acting morphine daily with an additional possible 180 mg short-acting morphine daily for breakthrough pain. The patient had not had relief with other treatments. Documentation regarding urine testing and weaning strategies is not present. Criteria for opioid use have not been met in this patient.

Morphine Sulfate (prospective medication request): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDS have failed. Opioids are considered a second-line treatment for several reasons: (1) head-to-head comparisons have found that opioids produce more side effects than TCAs and gabapentin; (2) long-term safety has not been systematically studied; (3) long-term use may result in immunological and endocrine problems (including hypogonadism); (4) treatment may be associated with hyperalgesia; & (5) opioid use is associated with misuse/abuse. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. In this case the medication was not prescribed for short term use and the criteria for opioid use were not met. Furthermore the recommendation is that dosing does not exceed 120 mg oral morphine equivalents per day, and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the

cumulative dose. In this case the patient takes 320 long-acting morphine daily with an additional possible 180 mg short-acting morphine daily for breakthrough pain. The patient had not had relief with other treatments. Documentation regarding urine testing and weaning strategies is not present. Criteria for opioid use have not been met in this patient.