

Case Number:	CM13-0055624		
Date Assigned:	12/30/2013	Date of Injury:	06/18/1989
Decision Date:	03/24/2014	UR Denial Date:	10/31/2013
Priority:	Standard	Application Received:	11/21/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in California. 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 50 year old female who sustained a work-related injury on 6/18/89 when she slipped on a wet floor. Her treatment history included pain medication, physical therapy, massage, an exercise program, nerve blocks, psychotherapy, relaxation training, trigger point injections, surgery, acupuncture, braces/casts, traction, a TENS unit, and chiropractic therapy. The patient underwent removal of hardware, exploration and augmentation of the fusion and re-entry laminotomy for nerve root neurolysis on 8/9/94. Medications included Morphine sulfate, Valium, Celebrex, baclofen, Avinza, and diazepam. An MRI of cervical spine performed on 1/6/14 revealed C5-6 moderate disc degeneration with circumferential 2-3mm disc bulge/osteophyte causing slight cord displacement with borderline central canal stenosis and mild bilateral foraminal narrowing; C6-7 moderate disc degeneration with 2mm circumferential bulge and mild bilateral foraminal narrowing; C4-5 and C7-T1 mild disc degeneration and slight bulging; and loss of lordosis with mild cervical kyphosis. An MRI of the thoracic spine performed 1/6/14 revealed mild T5-6 and T6-7 disc degeneration. There was no disc protrusion, stenosis or fracture identified, and mild multilevel mid and lower cervical disc degeneration, bulging and facet arthropathy was partially visualized. An MRI of the cervical spine without contrast performed on 9/25/07 revealed moderate caudally extruded midline disc herniation at C6-7 which abuts the anterior aspect of the cord without cord compression or displacement, and without apparent significant mass effect upon the lateral recesses or neural foramen; mild diffuse posterior disc bulging or protrusion at C5-6 with associated mild to moderate circumferential endplate spurring which abuts the anterior aspect of the cord, but without significant lateral recess or neural foramen encroachment identified; mild midline diffuse posterior protrusion of the C3-4 disc without significant mass effect noted; hemangiomas noted at C3, C4 and C5 vertebral bodies; and mild kyphotic curvature to the cervical spine centered at C5-6. An MRI of

the lumbar spine with/without contrast performed on 5/18/07 revealed status post instrumented interbody fusion of L4-5, and markedly degenerated disc at the L3-4 level, along with some posterior element hypertrophic changes and a mild or grade 1 spondylolisthesis. There were considerable reactive changes involving adjacent vertebral body endplates at this level, and some discitis there cannot be excluded in the appropriate clinical setting. Right-sided neural foraminal encroachment with probably nerve root impingement is also demonstrated at this level, secondary to a right posterolateral disc protrusion or herniation extending into the right neural foramen, and significant bilateral facet hypertrophic changes at the L5-S1 level, as described, with a small right facet joint effusion. This produced some posterolateral impression upon the thecal sac without definite spinal stenosis; however, there was evidence for bilateral neural foraminal stenosis, and some nerve root impingement could not be excluded. There was a mild right posterolateral disc bulge also noted there. An MRI performed 2/8/02 revealed mild reversal of the cervical lordosis was present between C3 and C7. The apex was at a mildly degenerated C5-6 disc with disc space narrowing and anterior end plate osteophytes; cervical lordosis reversal commonly reflects patient positioning or spasm of the anterior neck muscles, and can be related to the disc degeneration. Radiofrequency medial branch neurotomy at L2, L3 and L5 right and radiofrequency medial branch neurotomy at L2, L3 and L5 left was performed on 11/19/12. A clinic note dated 9/17/13 showed her cervical range of motion on focal examination at approximately 45 degrees of flexion and 0 degrees extension. Her thoracolumbar range of motion showed approximately 60 degrees of forward flexion, including approximately 30 degrees of lumbar flexion and 30 degrees of hip rotation. She refused hip and lumbar extension, describing increased pain and burning associated with the maneuver. She slowly limited her side bending left and right to approximately 10% based on the report of increased pain associated with the maneuver. She was able, however, to perform normal walking with a slightly antalgic gait pattern. Her right hip was slightly externally rotated to approximately 30 degrees. She appeared to have preferential weight-bearing on her left. She was able, however, to perform a deep knee bend and was able to toe and heel walk without difficulty. Her neurologic examination revealed intact light touch and temperature sensibility throughout all dermatomes with the presence of sensor dysesthesia and hyperesthesia in a nondermatomal distributing extending over many body segments in addition to frank allodynia in an area surrounding the lumbar spine. The patient had an absent left patellar reflex with present bilateral Achilles reflexes of +2/5 bilaterally symmetrical. The biceps, triceps, and brachioradialis reflexes were 2/+ bilaterally symmetrical. Her motor strength was +5/5 bilaterally symmetrical. She had negative straight leg raise and negative slump test. The patient was diagnosed with chronic low back, bilateral leg, right head, scalp, bilateral shoulders, and upper and mid back pain, as well as a history of lumbar degenerative disk disease, multilevel. An emergency department note performed 10/18/13 stated diagnoses of chronic pain and issue of repeat prescription. Medications prescribed at that visit were 5 Norco 5/325mg and 1 Ambien 5mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

240 morphine sulfate 30mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Medicine and Regional Anesthesia, 2nd Edition, 2005, Chapter 13: Opioid Therapy: Adverse Effects Including Addiction, pages 113-123.

Decision rationale: As per the California MTUS guidelines, morphine sulfate is recommended for controlling chronic pain and is often used for intermittent or breakthrough pain. Guidelines indicate that four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Based on current documentation, there is no evidence of functional improvement from long-term use of this medication. Records do not indicate that the patient has a decreased pain level or objective functional improvement with use of this medication. Also, there is no recent urine drug screen provided to support compliancy of this medication. Therefore, the request for morphine sulfate is not medically necessary.

90 morphine sulfate ER 60mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Medicine and Regional Anesthesia, 2nd Edition, 2005, Chapter 13: Opioid Therapy: Adverse Effects Including Addiction, pages 113-123.

Decision rationale: As per the California MTUS guidelines, morphine sulfate is recommended for controlling chronic pain and is often used for intermittent or breakthrough pain. Guidelines indicate that four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Based on current documentation, there is no evidence of functional improvement from long-term use of this medication. Records do not indicate that the patient has a decreased pain level or objective functional improvement with use of this medication. Also, there is no recent urine drug screen provided to support compliancy of this medication. Therefore, the request for morphine sulfate is not medically necessary.

120 Diazepam 10mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Medicine and Regional Anesthesia, 2nd Edition, 2005, Chapter 14: Psychopharmacology for Pain Medicine, pages 124-133.

Decision rationale: As per the California MTUS and the Official Disability Guidelines, benzodiazepines are only recommended for short-term use due to risk of tolerance, dependence, unproven efficacy, and adverse events. Most guidelines limit their use to four weeks. This patient has been on this medication for prolonged period of time and, therefore, the request for Diazepam is not certified.

