

Case Number:	CM14-0152715		
Date Assigned:	09/22/2014	Date of Injury:	09/15/2004
Decision Date:	12/11/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	09/18/2014

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 Occupational 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 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 claimant injured his cervical and lumbar spines in a fight at work on 09/15/04. Morphine 100 mg #60 is under review. He is status post L4-5 and L5-S1 posterior interbody fusion in November 2005 and as C5-C7 anterior cervical discectomy and fusion. He has tried to wean off medications without success according to a note dated 08/26/14. He had well-healed incisions of the cervical and lumbar spines with full range of motion and some tenderness but no neurologic deficits. Hardware removal and continuation of morphine were recommended. A prior UR review dated 05/06/14 provided a 2 month weaning period for the morphine. The claimant underwent surgery on 03/22/14. An internal medicine consultation dated 03/22/14 indicates that he was taking morphine, naproxen, Soma, and Valium. He was diagnosed with cervical radiculopathy status post cervical discectomy and fusion on 03/22/14 and had sinus bradycardia, chronic obstructive lung disease, anxiety and nervousness, and a history of smoking. He was stable postoperatively. On 04/04/14, medical detox was recommended as a possibility. His hardware was intact. Hardware removal was recommended on 08/26/14 and his medications were continued. His pattern of use of his medications is not described.

IMR ISSUES, DECISIONS AND RATIONALES

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

Morphine 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain Medications for Chronic Pain Page(s): 110; 94.

Decision rationale: The history and documentation do not objectively support the request for the opioid, morphine 100mg #60. The MTUS outlines several components of initiating and continuing opioid treatment and states "a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or nonsteroidal anti-inflammatory drugs. MTUS further explains, "pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts." There is no indication that periodic monitoring of the claimant's pattern of use and response to this medication, including assessment of pain relief and functional benefit, has been or will be done. There is no evidence that he has been involved in an ongoing rehab program to help maintain any benefits he receives from treatment measures. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors" should be followed and documented per the guidelines. The claimant's pattern of use of morphine is unclear other than he takes it. There is no evidence that a signed pain agreement is on file at the provider's office and no evidence that a pain diary has been recommended and is being kept by the claimant and reviewed by the prescriber. No urine drug screens have been documented to support compliance. As such, the medical necessity of the ongoing use of morphine 100 mg #60 has not been clearly demonstrated.