

Case Number:	CM14-0160997		
Date Assigned:	11/03/2014	Date of Injury:	11/09/1995
Decision Date:	01/30/2015	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	10/01/2014

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 Internal 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 patient is an injured worker with a history of lumbosacral spine injury. Date of injury was November 9, 1995. Mechanism of injury was motor vehicle accident. The progress report dated April 08, 2014 documented subjective complaints of low back pain. The patient states that he is still doing fairly well since the lumbar epidural injection on March 4, 2014. He is still having decreased pain in both his back and legs. He is still getting by with less of the Morphine and he is using this twice daily instead of three times daily. He states that his pain level is about 6/10 on the VAS visual analogue scale with medication. Lumbar spine MRI magnetic resonance imaging dated June 19, 2008 demonstrated degenerative change and spondylosis of the lumbar spine, postoperative imaging artifact in the lower lumbar spine, L4-5 mild bilateral foraminal narrowing, L5-S1 broad-based disc protrusion with effacement of the anterior epidural space and mild abutment of the anterior thecal sac. There is obscuration of the foramina. There is probably moderate right and mild left foraminal narrowing. Lumbar spine MRI magnetic resonance imaging dated July 20, 2012 demonstrated moderate bilateral facet arthrosis and ligamentous hypertrophy at L3-4. At L5-S1, there is severe loss of disc height and moderate endplate spondylosis. There is no disc herniation. There is moderate bilateral intervertebral neural foraminal narrowing. There is mild paraspinal muscular atrophy. Stable appearing post-surgical changes at L4-5 and L5-S1. Straightening of the normal lumbar lordosis was noted. There are no disc herniations. Medications included Cymbalta, Baclofen, Ketamine 5% cream, and Morphine Sulfate ER 30 mg one tablet every 12 hours. Diagnoses included lumbar disc displacement and postlaminectomy syndrome lumbar and secondary revision in 2002. Treatment plan was documented. The patient continues to have low back pain. He is still having good pain relief following the lumbar epidural steroid injection a month ago. He has been able to decrease his medication use and is using Morphine twice daily with benefit. Prescriptions included Baclofen,

Cymbalta, and Ketamine topical cream. The progress report dated September 9, 2014 documented low back pain. The patient states that his pain is setting worse and worse. He reports waking up frequently during the night because of his lower extremity pain and numbness. He states that he is only getting a couple of hours of sleep per night. He states that for three nights he could not stretch out his legs because of the pain going down the back of his legs. The patient would like to repeat the lumbar epidural injection because he has had significant pain relief with these injections in the past. The most recent injection was on March 4, 2014, which gave him greater than fifty percent decrease in his back and lower extremity pain and lasted about three months. He was able to decrease his use of Morphine from three tablets per day down to two tablets per day for several months after the injection. He is getting more desperate because of his worsening pain. The epidural injections help to keep his pain more stable and his is able to better tolerate it with the medications and the injections. Lumbar fusion L4-S1 surgery was performed in 2002. Physical examination was documented. Patient is alert and oriented. Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation. Patient has antalgic gait. Normal muscle tone without atrophy in the extremities was noted. Lumbar extension was measured to be 10 degrees. Lumbar flexion was measured to be 50 degrees. Straight leg raise is positive on left and right. Spasm and guarding is noted lumbar spine. The patient reports having about thirty percent decreases in pain with use of his Morphine. He denies any side effects from the Morphine. His most recent urine screen on June 10, 2014 showed the presence of opioids without any inconsistencies. CURES controlled substance utilization review and evaluation system reports have been consistent. Morphine Sulfate ER 30 mg one tablet every eight hours quantity ninety was prescribed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Morphine Sulf ER 30mg - one (1) tab PO every eight (8) hours #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids..

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines (page 89) present the strategy for maintenance for long-term users of opioids. "Do not attempt to lower the dose if it is working." Supplemental doses of break-through medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain. Actual maximum safe dose will be patient-specific and dependent on current and previous opioid exposure, as well as on whether the patient is using such medications chronically. Medical records document that lumbar fusion L4-S1 spine surgery was performed in 2002. Medical records document objective evidence of pathology. Lumbar spine MRI magnetic resonance imaging document pathology. Analgesia, activities of daily living, adverse side effects, and aberrant behaviors were addressed. Medical records document regular physician clinical evaluations. Medical records provide support for the prescription of Morphine Sulfate ER 30 mg. The request for Morphine Sulfate ER 30 mg is supported by MTUS guidelines and

medical records. Therefore, the request for Morphine Sulf ER 30mg - one (1) tab PO every eight (8) hours #90 is medically necessary.

Ketamine 5 percent cream 60 gr- apply to affected area t.i.d. #2: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Ketamine Page(s): 111-11 and , 56.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. MTUS Chronic Pain Medical Treatment Guidelines (Page 56) state that Ketamine is not recommended. There is insufficient evidence to support the use of Ketamine for the treatment of chronic pain. There are no quality studies that support the use of Ketamine for chronic pain. Ketamine was associated with frequent side effects. MTUS guidelines do not support the use of Ketamine. Therefore, the request for Ketamine 5 percent cream 60 gr-apply to affected area t.i.d. #2 is not medically necessary.

Baclofen 10mg - One (1) PO t.i.d. #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines antispasticity drugs, muscle relaxants.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47,Chronic Pain Treatment Guidelines Muscle relaxants. Page(s): 63-66. Decision based on Non-MTUS Citation FDA Prescribing Information Baclofen, <http://www.drugs.com/pro/baclofen.html>

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses muscle relaxants. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) states that muscle relaxants seem no more effective than NSAIDs for treating patients with musculoskeletal problems, and using them in combination with NSAIDs has no demonstrated benefit. Muscle relaxants may hinder return to function by reducing the patient's motivation or ability to increase activity. Table 3-1 states that muscle relaxants are not recommended. Chronic Pain Medical Treatment Guidelines (Page 63-66) addresses muscle relaxants. Muscle relaxants should be used with caution as a second-line option for short-term treatment. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. According to a review in American Family Physician, muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Baclofen is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. FDA Prescribing Information states that Baclofen is indicated for spasticity resulting from multiple sclerosis. Baclofen may also be of some value in patients with spinal cord injuries and other spinal cord diseases. Baclofen is not indicated in the treatment

of skeletal muscle spasm resulting from rheumatic disorders. The efficacy of Baclofen in stroke, cerebral palsy, and Parkinson's disease has not been established and, therefore, it is not recommended for these conditions. Medical records document that the patient has chronic occupational injuries and has been prescribed muscle relaxants long-term. MTUS guidelines do not support the long-term use of muscle relaxants. Medical records do not document multiple sclerosis or spinal cord injury. MTUS and FDA guidelines recommend Baclofen only for multiple sclerosis or spinal cord diseases. MTUS, ACOEM, and FDA guidelines do not support the use of Baclofen. Therefore, the request for Baclofen 10mg - One (1) PO t.i.d. #90 is not medically necessary.