

Case Number:	CM15-0189309		
Date Assigned:	10/01/2015	Date of Injury:	04/11/2004
Decision Date:	11/09/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/25/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 54 year old female who reported an industrial injury on 4-11-2004. Her diagnoses, and or impressions, were noted to include chronic neck pain; cervical spondylosis without myelopathy; chronic low back pain; chronic left lumbar radicular pain; and drug-induced constipation. Recent computed tomography of the brain was done on 7-20-2015; no current imaging studies were noted. Her treatments were noted to include cervical x-rays (5-22-12); cervical magnetic resonance imaging studies (2-17-11); neurology consultation (3-13-15); medication management; and rest from work, with a totally disabled classification on 3-13-2015. The progress notes of 8-20-2015 reported: an increase, over 2 months, in low back pain, rated 4-6 out of 10, that extended down her right lower limb-posterior thigh-lateral calf-top of foot, now associated with an unusual sensation of water running down her leg; and that she continued taking her opioid analgesic medications. The objective findings were noted to include: that her Brief Pain Inventory Interference Scale score was 39 out of 70; a review of the 2-1-2011 & 5-22-2012 lumbar x-rays, noting no significant changes; and that her low back pain had worsened and was now associated with right-sided sciatica, with now absent lower extremity reflexes. The physician's requests for treatment were noted to include the continuation of chronic opioid analgesic therapy to control her otherwise intractable pain, with an attempt to lower the dose from 180 mg daily, to 150 mg daily. The Request for Authorization (RFA), dated 8-25-2015, was noted to include Morphine ER 60 mg, #60, 1 twice a day; and Morphine ER 30 mg, #30, 1 daily at noon. The Utilization Review of 9-1-2015 non-certified the request for Morphine ER 30 mg, #30. The 12-29-2014 and 1-26-2015 progress notes show her being on Morphine ER 150

mg daily in divided doses, (9-20-2011). The RFA dated 2-23-2015 noted continuation of Morphine ER 60 mg, #60 and Morphine ER 30 mg, #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Morphine ER 30mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, dosing.

Decision rationale: The claimant has a remote history of a work injury in April 2004 with a twisting injury to the low back and is being treated for chronic pain. In May 2015 extended release morphine was being prescribed at a total MED (morphine equivalent dose) of 135 mg per day and had been prescribed since September 2011. Medications were providing 50% pain relief with improved activities of daily living. In July 2015 her medications had been denied and had been provided through her primary care provider. The denial had been overturned and the requesting provider resumed prescribing. Medications were refilled at the same MED. When seen in August 2015, she was having increasing pain rated at 4-6/10. A limited normal physical examination is documented. Although the report references attempting to lower the dose from 180 mg to 150 mg per day, it was actually increased from 135 mg to 150 mg per day. Guidelines recommend against opioid dosing is in excess of 120 mg oral morphine equivalents per day. In this case, the total MED being prescribed is more than that recommended. Although the claimant has chronic pain and the use of opioid medication may be appropriate, there are no unique features of this case that would support dosing at this level, and, rather than weaning of the currently prescribed medications as is referenced in the requesting provider's report, the dose was increased. Ongoing prescribing at this dose is not considered medically necessary.