

Case Number:	CM15-0084333		
Date Assigned:	05/28/2015	Date of Injury:	09/11/2002
Decision Date:	06/25/2015	UR Denial Date:	04/03/2015
Priority:	Standard	Application Received:	05/01/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 injured worker is a 54 year old female, who sustained an industrial injury on September 11, 2002. She reported slipping on a wet floor, falling on her back and feeling a burning sensation in her back. The injured worker was diagnosed as having chronic low back pain, lumbosacral radiculopathy, status post lumbar surgeries, neurogenic bladder, bladder neck dyssynergia, major depressive disorder/single episode/severe with psychotic features, reflux esophagitis, drug induced constipation, hypertension, hypothyroidism, migraine, and resolved right sided cellulitis. Treatment to date has included cognitive behavioral therapy, lumbar surgeries, epidural injections, and medication. Currently, the injured worker complains of low back pain. The Primary Treating Physician's report dated March 20, 2015, noted the injured worker reported her present pain intensity was 7/10, with average pain intensity for the week 9/10, noting her Morphine reduces her pain intensity by 60%. The Morphine was noted to help reduce her pain and allowed the injured worker to be more active in terms of her household activities. The injured worker's mood was noted to be brightened since starting cognitive behavioral therapy. Physical examination was noted to show the injured worker ambulated with the assistance of a single point cane, with tone in her lower limbs normal, and reflexes at the knees and left ankle normal, with trace at the right ankle. The treatment plan was noted to include the injured worker's medications, including Duloxetine, Morphine ER, Omeprazole DR, Polyethylene Glycol, Quetiapine, and Naproxen from the provider, and Myrbetrig, Levothyroxine, Enalapril, and Topiramate from additional providers. The Physician noted the injured worker would continue long-term opioid analgesic therapy with the goals to control her

chronic otherwise intractable pain, improve her tolerance for daily activities, and improve her quality of life. The Physician noted a CURES report was consistent with her prescription history, a urine drug screen (UDS) was consistent with her treatment history, and there was a signed treatment agreement for the treatment with controlled substances. The Physician noted writing a prescription for Extended Release Morphine, with an additional prescription to be filled in four weeks. The injured worker was noted to be temporarily totally disabled on a psychiatric basis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Morphine ER 30mg #84 x 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor- shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented

evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant improvement in VAS scores. There are also no objective measurements of improvement in function. Therefore, criteria for the ongoing use of opioids have not been met and the request is not medically necessary.