

<b>Case Number:</b>	CM14-0154802		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	04/01/2005
<b>Decision Date:</b>	02/11/2015	<b>UR Denial Date:</b>	09/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2014

### 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 lumbar spine surgery. Date of injury was April 1, 2005. The orthopedic specialist consultation report dated June 23, 2014 documented that the patient was injured during his usual work activities April 1, 2005. He required an L4-5 transforaminal lumbar interbody fusion and decompression July 20, 2006 and was declared permanent and stationary from this injury July 11, 2007. He developed increasing complaints of lower back and bilateral leg pain requiring the use of a cane for ambulation. Medications included Norco and MS Contin. He has not been able to return to work since the injury occurred. There was one attempt at placement of a spinal cord stimulator which was aborted due to technical difficulties. The patient complains of left greater than right leg and lower back pain, the pain in the legs radiating to the feet. Past medical history is remarkable for the above noted spinal surgeries and attempted spinal cord stimulator placement as well as depression. Regularly used medications include Norco and MS Contin. The patient denies drug allergies. Family history is negative. Social history is remarkable for smoking a quarter-pack of cigarettes per day and negative for the use of alcohol. The patient is married. Physical examination was documented. Examination of the lumbar spine reveals an eight-inch lumbar surgical scar; otherwise no skin abnormality, deformity or palpable spasm. No tenderness is present. Range of motion allows for 70 degrees of flexion at the hips with forward reach to the shin, extension of 30 degrees and lateral bending of 20 degrees to both sides. He is unable to stand up straight. Straight leg raising bilaterally causes lower back and ipsilateral leg pain. Neurologic exam of the lower extremities is intact with regard to motor strength and sensation. Deep tendon reflexes are unobtainable. Radiographic studies X-rays of the lumbar spine showed five lumbar vertebrae with L4-5 anterior interbody fusion with peek spacer which appears to be well incorporated. He has disc space narrowing at L5-6 and L6-S1, the L6-S1 level probably congenitally fused,

representing a transitional level with lumbarized S1 or partially sacralized L6. Otherwise there are normal disc spaces, normal lumbar lordosis and alignment, no evidence of instability or stress fracture, no significant degenerative changes and no evidence of foraminal stenosis or narrowing. Diagnoses were L4-5 transforaminal lumbar interbody fusion July 20, 2006, spondylosis, and lumbar and bilateral lower extremity sciatic leg pain. Utilization review determination letter dated September 2, 2014 documented that the urine drug screen performed in March 2014 was inconsistent with the detection of marijuana metabolites. Positive urine drug test for marijuana was noted. The primary treating physician's progress report dated July 31, 2014 document pain and medications Morphine Sulfate and Norco. Physical examination documented lumbar pain and decreased range of motion. Diagnosis was status post lumbar fusion. The physician noted new onset of edema could be due to the Morphine Sulfate. Utilization review determination letter date was September 2, 2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Morphine Sulfate 30mg ER, Days supply 13, Quantity 35, MED 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 80-81.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 47-48; 308-310, Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address opioids. The lowest possible dose should be prescribed to improve pain and function. Immediate discontinuation has been suggested for evidence of illegal activity including diversion. Frequent evaluation of clinical history and frequent review of medications are recommended. Periodic review of the ongoing chronic pain treatment plan for the injured worker is essential. Patients with pain who are managed with controlled substances should be seen regularly. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 3 states that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal symptoms. Opioids should be used only if needed for severe pain and only for a short time. ACOEM guidelines state that the long-term use of opioids is not recommended for back conditions. Medical records document the long-term use of opioids. ACOEM guidelines indicate that the long-term use of opioids is not recommended for back conditions. The primary treating physician's progress report dated July 22, 2014 documented that the patient reported sedation with Morphine Sulfate. The primary treating physician's progress report dated July 31, 2014 documented that the physician noted that new onset of edema could be due to the Morphine Sulfate. Adverse side effects were reported. The 7/31/14 progress report did not address activities of daily living. Utilization review determination letter dated September 2, 2014 documented that the urine drug screen performed in March 2014 was inconsistent with the detection of marijuana metabolites. Positive urine drug test for marijuana was noted. The urine drug screen was potentially aberrant. Per MTUS guidelines, immediate discontinuation has been suggested for evidence of illegal activity

including diversion. The request for Morphine Sulfate is not supported by MTUS guidelines. Therefore, the request for Morphine Sulfate 30mg ER, Days supply 13, Quantity 35, MED 90 is not medically necessary.