

Case Number:	CM15-0094825		
Date Assigned:	05/20/2015	Date of Injury:	10/31/2013
Decision Date:	06/24/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/15/2015

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 41-year-old female patient who sustained an industrial injury on 10/31/2013. The accident was described as while working as a support aide caregiver the person lost her balance and tried to correct by grabbing the persons waist resulting in the patient twisting her body causing her to fall backwards with resulting injury. She immediately began experiencing pain in the low back and had difficulty getting up off the floor. A primary treating office visit dated 03/30/2015 reported chief complaint of low back pain. She has subjective complaint of having intermittent fluctuating dull achy pain in the low back that radiates down the bilateral legs to the feet, right greater. She also reports associated numbness to the 2nd, 4th, and 5th digits of bilateral toes. She does get some relief with walking and participates daily using a single point cane and a walker. Treatment history to include: radiographic study of cervical spine done on 03/11/2015 that showed mild spondylosis, and loss of lordosis. The lumbar spine radiography done that same date 03/11/2015 showed disc space narrowing moderate L4-5, moderate to severe L5-S1. Electric diagnostic nerve conduction study of upper extremities performed on 03/17/2015 revealed abnormal study with mild evidence of bilateral carpal tunnel syndrome with median entrapment at wrist affecting the sensory components. The lower extremity nerve conduction study showed a normal study with no evidence of focal nerve entrapment, lumbar radiculopathy or generalized peripheral neuropathy affecting the lower limbs. Current medications are Baclofen, Neurontin, morphine 15mg and over the counter stool softeners. She states that taking Baclofen, Neurontin, and the Morphine reduces her pain form a 6 out of 10 to a 3-4 intensity; denies side effect. She does smoke Cannabis. A neurological evaluation noted the patient with decreased sensation to left L4-15 dermatomes, and a positive

Faber's on the right. A CURES report from 03/30/2015 is consistent with prescribed medications. The following diagnoses are applied: rule out intradiscal injury cervical spine; rule out intradiscal injury lumbar spine, lumbar radiculopathy, neck pain, and back pain. The plan of care involved: recommendation to undergo another MRI of lumbar spine, re-assessment for injection, continue with medications and refilled morphine Sulfate IR 15mg #90, Baclofen #60, and Neurontin 600mg one daily then one a week increase to 600mg twice daily thereafter. She is to follow up in 4 weeks. Back on 03/24/2014 the assessment showed the following treating diagnoses applied: degeneration of intervertebral disc; carpal tunnel syndrome; degeneration of lumbar intervertebral disc; lumbar spondylosis; radiculitis; gastritis; low back pain; hip pain, and chronic back pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Baclofen 10mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-65.

Decision rationale: The California chronic pain medical treatment guidelines section on muscle relaxants states: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. In addition, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) (Chou, 2004) This medication is not intended for long-term use per the California MTUS. The medication has not been prescribed for the flare-up of chronic low back pain. This is not an approved use for the medication. For these reasons, criteria for the use of this medication have not been met. Therefore, the request is not medically necessary.

Morphine Sulfate 15mg #90: Upheld

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

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 non-adherent) 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 non-opioid 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.