

Case Number:	CM14-0121657		
Date Assigned:	08/06/2014	Date of Injury:	02/23/2011
Decision Date:	09/16/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/01/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 a 50-year-old male with date of injury of 02/23/2011. The listed diagnoses dated 06/17/2014 are: Chronic low back pain, Degenerative lumbar spondylosis, Myofascial pain syndrome, chronic neck pain, Degenerative cervical spondylosis and Pain disorder with psychological general medical condition. According to this report, the patient complains of chronic low back pain due to degenerative spondylosis of the lumbar spine. He has tried adjuvant analgesics such as gabapentin and Lyrica. He is currently using an antiinflammatory (ibuprofen). The patient has successfully used medical marijuana focusing on products with a high concentration of CBDs (analgesic components) and little or none of the THC. He reports partial pain relief with his current analgesic medications. His current analgesic medications help him maximize his level of physical function and improve his quality of life. The objective findings show the patient is alert, cooperative with no evidence of medication overuse. Muscle spasms were noted in the lumbar paraspinal/gluteus muscles. There is positive guarding of the right lower extremity. DTR right adductor magnus is decreased, 1+ compared to 2+ on the left. Straight leg raise test is positive on the right. Radiculopathy was noted on the right L5. The utilization review denied the request on 07/31/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural steroid injection (ESI) of the lumbar spine to treat (R) L5 radiculopathy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines The Medical Treatment Utilization Schedule has the following regarding ESI's, under its chronic pain section Page(s): 46, 47.

Decision rationale: This patient presents with chronic low back pain. The treater is requesting an epidural steroid injection at the right L5. The MTUS guidelines page 46 and 47 on epidural steroid injection recommends this option for treatment of radicular pain as defined by pain in a dermatomal distribution with corroborative findings in an MRI. Repeat blocks should be based on continued objective documented pain and functional improvement including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks. The records do not show any recent MRI reports of the lumbar spine; however, the records reference an MRI of the lumbar spine on 08/27/2012 that showed "right L5 radiculopathy." The progress report dated 06/17/2014 notes that the patient has a positive straight leg raise on the right with the patient reporting burning, shooting pain in the posterior right leg. In this case, MTUS Guidelines require corroborating imaging study that explains the patient's radicular symptoms. The treater does not discuss MRI findings that would explain the patient's right leg symptoms. Recommendation is for denial.

Retrospective request: Urine drug screen (UDS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Testing (UDT)Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) On-Line <http://www.odg-twc.com/odgwc/pain.htm>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines have the following regarding Urine Drug Screen:Criteria for Use of Urine Drug TestingUrine drug tests may be subject to specific drug screening statutes and regulations based on state and local laws, and the requesting clinician should be familiar with these. State regulations may address issues such as chain of custody requirements, patient privacy, and how results may be used or shared with employers. The rules and best practices of the U.S. Department of Transportation should be consulted if there is doubt about the legally defensible framework of most jurisdictions. (DOT, 2010)1. A point-of-contact (POC) immunoassay test is recommended prior to initiating chronic opioid therapy. This is not recommended in acute care situations (i.e. for treatment of nociceptive pain). There should be documentation of an addiction-screening test using a formal screening survey in the records prior to initiating treatment. If the test is appropriate, confirmatory lab testing is not required. See Opioids, screening tests for risk of addiction & misuse.2. Frequency of urine drug testing should be based on documented evidence of risk stratification including use of a testing instrument. See Opioids, tools for risk stratification & monitoring.An explanation of "low risk," "moderate risk," and "high risk" of addiction/aberrant behavior is found under Opioids, tools for risk stratification & monitoringand Opioids, screening tests for risk of addiction & misuse.3. Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on

a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only.⁴ Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. This includes patients undergoing prescribed opioid changes without success, patients with a stable addiction disorder, those patients in unstable and/or dysfunction social situations, and for those patients with comorbid psychiatric pathology.⁵ Patients at "high risk" of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders.⁶ If a urine drug test is negative for the prescribed scheduled drug, confirmatory testing is strongly recommended for the questioned drug. If negative on confirmatory testing the prescriber should indicate if there is a valid reason for the observed negative test, or if the negative test suggests misuse or non-compliance. Additional monitoring is recommended including pill counts. Recommendations also include measures such as prescribing fewer pills and/or fewer refills. A discuss

Decision rationale: This patient presents with chronic low back pain. The treater is requesting a retrospective request for a urine drug screen. While the MTUS Guidelines do not specifically address how frequent urine drug screen should be obtained for various risk opiate users, ODG Guidelines provide a clear guideline. For low risk opiate users, a yearly urine drug screen is recommended following the initial screening within the first six months. The UR denied the request stating that the patient is not being treated with an opioid medication, and no documentation of aberrant behavior or suspicion of illicit drug use was noted. The 06/17/2014 report lists the patient's current medications including: ibuprofen, lisinopril, and Lidoderm patches. In the same report, the patient reports that he is currently using medical marijuana for pain control. In this case, the treater is requesting UDS to confirm the usage of prescribed "daily use" not p.r.n. analgesic medicines and document the presence and absence of any street drugs/prescription medicines not provided by the treater. However, the treater is not prescribing any opiates. Urine toxicology is for opiates management and for management of other medications prescribed. Recommendation is for denial.