

<b>Case Number:</b>	CM14-0179397		
<b>Date Assigned:</b>	11/03/2014	<b>Date of Injury:</b>	05/01/2007
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	10/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2014

### 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 & Rehabilitation, has a subspecialty in Pain 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 injured worker is a 64-year-old female who reported an injury on 05/01/2007 due to an unknown mechanism. Diagnoses were lumbago; thoracic or lumbosacral neuritis or radiculitis unspecified; post-laminectomy syndrome, cervical region; osteoarthritis, generalized, multiple sites; and opioid dependence. The injured worker is status post corpectomy/fusion, left knee replacement, left thumb tendon release, left rotator cuff and bone spur, C5-7 anterior corpectomy/fusion, right rotator cuff and bone spur, right knee replacement, right knee meniscus repair, right knee meniscus repair, gallbladder removal, hysterectomy, right and left hand carpal tunnel, tubal ligation. Physical examination on 10/01/2014 revealed that the pain was a 7/10; the injured worker related pain relief with medications and treatment over the last week was 60%. Examination revealed the injured worker reported heat intolerance, cold intolerance, thyroid problems, muscle weakness, excessive fatigue and difficulty sleeping. It was also reported that the injured worker complained of uncontrolled pain, baseline and breakthrough pain. It was reported that the provider was to increase her Fentanyl. Medications were not reported. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Urine drug screen and drug confirmation, provided on August 7, 2014:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Testing (UDT) Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Urine Drug Testing (UDT)

**Decision rationale:** The decision for Urine drug screen and drug confirmation, provided on August 7, 2014 is not medically necessary. The California Medical Treatment Utilization Schedule indicates that the use of urine drug screening is for patients with documented issues of abuse, addiction, or poor pain control. The California Medical Treatment Utilization Schedule does not provide enough information. Therefore, the Official Disability Guidelines references were sought. According to the Official Disability Guidelines, urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. The tests should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. This information includes clinical observation, results of addiction screening, pill counts, and prescription drug monitoring reports. The prescribing clinician should also pay close attention to information provided by family members, other providers and pharmacy personnel. The frequency of urine drug testing may be dictated by state and local laws. The Medical Guidelines state that typically screening assays are based on immunoassays, which cannot be either laboratory based or point of collection testing. Point of collection testing is also commonly referred to as dipstick testing. This latter type of testing is performed on site and usually requires no instrumentation. Substances are reported as present or absent at the predetermined cutoff threshold. Screening assays have the advantages of being more cost effective than confirmatory test and with point of contact systems, allow immediate results. These tests cannot identify a specific analyze or distinguish between different drugs of the same class. The medical guidelines state that confirmatory testing is laboratory based specific drug identification, which includes gas chromatography/mass spectrometry or liquid chromatography tandem mass spectrometry. These tests allow for identification and quantification of specific drug substances. They are used to confirm the presence of a given drug, and/or to identify drugs that cannot be isolated by screening tests. The tests also allow for identification of drugs that are not identified in the immunoassay screen. These are generally considered confirmatory tests and have a sensitivity and specificity of around 99%. These tests are particularly important when results of a test are contested. When to perform a confirmation is when the point of contact screen is appropriate for the prescribed drugs without evidence of non-prescribed substances, confirmation is generally not required. Confirmation should be sought for all samples testing negative for prescribed drugs, all samples positive for non-prescribed opioids, and all samples positive for illicit drugs. It was not reported that the injured worker was participating in an aberrant drug taking behavior. It was not reported that the injured worker had previous urine samples that were positive for illicit drugs or for non-prescribed opioids. There were no other significant factors to justify urine drug screen and drug confirmation provided on 08/07/2014. Therefore, this request is not medically necessary.

**Lidoderm patch, ninety count with three refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine, Topical Analgesic Page(s): 112,111.

**Decision rationale:** The decision for Lidoderm patch, #90 with three refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines indicate that topical Lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of trial of a first line therapy (tricyclic or SNRI antidepressant or an AED such as Gabapentin or Lyrica). No other commercially approved topical formulation of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The efficacy of this medication was not reported. It also was not reported where the injured worker was to apply the Lidoderm patch. The Medical Guidelines state that Lidoderm is not recommended until there is evidence of a first line therapy such as tricyclic, SNRI antidepressant or AED has been tried and failed. Also, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

**Cyclobenzaprine Hydrochloride 10 mg, #70:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41,64.

**Decision rationale:** The decision for Cyclobenzaprine Hydrochloride 10 mg #70 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines states that Cyclobenzaprine (Flexeril) is recommended for a short course of therapy. Flexeril is more effective than placebo in the management of back pain; however, the effect is modest and comes with the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. This medication is not recommended to be used for longer than 2 to 3 weeks. The efficacy of this medication was not reported. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Also, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.