

Case Number:	CM13-0044232		
Date Assigned:	12/27/2013	Date of Injury:	04/29/2003
Decision Date:	04/03/2015	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	10/28/2013

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: Ohio, North Carolina, Virginia
 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 55 year old female, who sustained an industrial injury on April 29, 2003. The diagnoses have included lumbago, chronic pain with radiculopathy, and status post lumbar 5-sacral 1 posterior lumbar interbody fusion in 2010. Treatment to date has included TENS (transcutaneous electrical nerve stimulation) unit, urine drug testing, blood testing, home exercises, physical therapy, single point cane use for balance, lumbar support brace, epidurals, positive trial of a spinal cord stimulator, and pain, anti-epilepsy, muscle relaxant, and anti-inflammatory medications. On November 19, 2013, the treating physician noted significantly increased lumbar pain with the cold weather. The physical exam revealed the injured worker lying on his side with his knees pulled up and a spacer between the knees for comfort. He was able to return to sitting with some difficulty, but without assistance. He walked with an antalgic gait and used a single point cane for balance. There was lumbar spine tenderness. The treatment plan included requests for Points of Contact and lab work for the next visit and to continue his current pain, anti-epilepsy, muscle relaxant, and anti-inflammatory medications. On October 28, 2013, the injured worker submitted an application for IMR for review of requests for follow-up visits (ongoing follow-up visits), Point of Contact urine drug screen, and Points of Contact and labs every three months for one year. The ongoing follow-up visits were modified based on the guidelines support follow-up visits as necessary to monitor and evaluate the treatment plan and make changes as needed. The Point of Contact urine drug screen was non-certified based on the results of February 27, 2013 testing and the lack of documentation of suggesting this patient has any increased risk of diversion to support the need for more frequent testing than once a year.

The Points of Contact and labs was non-certified based on the lack of rationale for testing labs every three months, and the lack of documentation of subjective symptoms or objective physical findings that would warrant an increased frequency of lab testing. The California Medical Treatment Utilization Schedule (MTUS): Chronic Pain Medical Treatment Guidelines, non-Medical Treatment Utilization Schedule (MTUS) guidelines, and the Official Disability Guidelines (ODG) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Point of Care (POC) Urine Drug Screen (date of service 09/10/2013): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, screening for the risk of addiction (tests) Page(s): 90-91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 94. Decision based on Non-MTUS Citation Official Disability Guidelines. Pain (Chronic) chapter. Urine drug testing section.

Decision rationale: Per the MTUS, to avoid misuse of opioids, and in particular, for those at high risk of abuse: a) Opioid therapy contracts. See Guidelines for Pain Treatment Agreement. b) Limitation of prescribing and filling of prescriptions to one pharmacy. c) Frequent random urine toxicology screens. The Official Disability Guidelines further clarify suggested frequencies for or urine drug testing. 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 test 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. Indications for UDT: At the onset of treatment: (1) UDT is recommended at the onset of treatment of a new patient who is already receiving a controlled substance or when chronic opioid management is considered. Urine drug testing is not generally recommended in acute treatment settings (i.e. when opioids are required for nociceptive pain). (2) In cases in which the patient asks for a specific drug. This is particularly the case if this drug has high abuse potential, the patient refuses other drug treatment and/or changes in scheduled drugs, or refuses generic drug substitution. (3) If the patient has a positive or 'at risk' addiction screen on evaluation. This may also include evidence of a history of comorbid psychiatric disorder such as depression, anxiety, bipolar disorder, and/or personality disorder. See Opioids, screening tests for risk of addiction & misuse. (4) If aberrant behavior or misuse is suspected and/or detected. If a patient has evidence of a 'high risk' of addiction (including evidence of a comorbid psychiatric disorder (such as depression, anxiety, attention-deficit disorder, obsessive-compulsive disorder, bipolar disorder, and/or schizophrenia), has a history of aberrant behavior, personal or family history of substance dependence (addiction), or a personal history of sexual or physical trauma, ongoing urine drug testing is indicated as an adjunct to monitoring along with clinical exams and pill counts. Frequency of urine drug testing

should be based on documented evidence of risk stratification including use of a testing instrument. 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. 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. 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. In this instance, the injured worker had a urine drug screen on 2-27-2013. The results were consistent with prescribed medicine. A review of the medical record does not indicate any concern that the injured worker was at moderate or high risk for addiction or aberrant drug taking behavior. The justification for performing urine drug testing more than once yearly is therefore lacking in the submitted medical record. Therefore, Point of Care (POC) Urine Drug Screen (date of service 09/10/2013) was not medically necessary.

POC's (Point of Care) Urine Drugs screening every three (3) months for one (1) year:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, screening for the risk of addiction (tests) Page(s): 90-91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 94. Decision based on Non-MTUS Citation Official Disability Guidelines. Pain (Chronic) chapter. Urine drug testing section.

Decision rationale: Per the MTUS, to avoid misuse of opioids, and in particular, for those at high risk of abuse: a) Opioid therapy contracts. See Guidelines for Pain Treatment Agreement. b) Limitation of prescribing and filling of prescriptions to one pharmacy. c) Frequent random urine toxicology screens. The Official Disability Guidelines further clarify suggested frequencies for or urine drug testing. 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 test 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. Indications for UDT: At the onset of treatment: (1) UDT is recommended at the onset of treatment of a new patient who is already receiving a controlled substance or when chronic opioid management is considered. Urine drug testing is not generally recommended in acute treatment settings (i.e. when opioids are required for nociceptive pain). (2) In cases in which the patient asks for a specific drug. This is particularly the case if this drug has high abuse potential, the patient refuses other drug treatment and/or changes in scheduled drugs, or refuses generic drug substitution. (3) If the patient has a

positive or 'at risk' addiction screen on evaluation. This may also include evidence of a history of comorbid psychiatric disorder such as depression, anxiety, bipolar disorder, and/or personality disorder. See Opioids, screening tests for risk of addiction & misuse. (4) If aberrant behavior or misuse is suspected and/or detected. If a patient has evidence of a 'high risk' of addiction (including evidence of a comorbid psychiatric disorder (such as depression, anxiety, attention-deficit disorder, obsessive-compulsive disorder, bipolar disorder, and/or schizophrenia), has a history of aberrant behavior, personal or family history of substance dependence (addiction), or a personal history of sexual or physical trauma, ongoing urine drug testing is indicated as an adjunct to monitoring along with clinical exams and pill counts. Frequency of urine drug testing should be based on documented evidence of risk stratification including use of a testing instrument. 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. 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. 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. In this instance, the injured worker had a urine drug screen on 2-27-2013. The results were consistent with prescribed medicine. A review of the medical record does not indicate any concern that the injured worker was at moderate or high risk for addiction or aberrant drug taking behavior. The justification for performing urine drug testing more than once yearly is therefore lacking in the submitted medical record. Therefore, the medical necessity for POC's (Point of Care) Urine Drugs screening every three (3) months for one (1) year has not been established.

Follow-up appointments with [REDACTED] (ongoing follow-ups): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Office Visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines. Low Back chapter. Office visits section.

Decision rationale: Office visits are recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per

condition cannot be reasonably established. In this instance, the injured worker has severe, chronic back pain and is dependent upon opioids. Office visits for follow up with Dr. [REDACTED] are medically necessary.

Unspecified Laboratory Testing every three (3) months for one (1) year: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.cigna.com/healthinfo/hw4260.html>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Lab tests online: Liver panel, Chem 8, CBC.

Decision rationale: The CBC is a very common test. Many people have a CBC performed when they have a routine health examination. If a person is healthy and has results that are within normal limits, then he or she may not require another CBC until their health status changes or until their doctor feels that it is necessary. A CBC may be ordered when a person has any number of signs and symptoms that may be related to disorders that affect blood cells. When an individual has fatigue or weakness or has an infection, inflammation, bruising, or bleeding, a doctor may order a CBC to help diagnose the cause and/or determine its severity. When a person has been diagnosed with a disease known to affect blood cells, a CBC will often be ordered on a regular basis to monitor their condition. Likewise, if someone is receiving treatment for a blood-related disorder, then a CBC may be performed frequently to determine if the treatment is effective. Some therapies, such as chemotherapy, can affect bone marrow production of cells. Some medications can decrease WBC counts overall. A CBC may be ordered on a regular basis to monitor these drug treatments. The basic metabolic panel (BMP) is a frequently ordered panel of 8 tests that gives a health practitioner important information about the current status of a person's kidneys, blood glucose level, and electrolyte and acid/base balance. Abnormal results, and especially combinations of abnormal results, can indicate a problem that needs to be addressed. The BMP includes the following tests: Glucose: energy source for the body; a steady supply must be available for use, and a relatively constant level of glucose must be maintained in the blood. Calcium: one of the most important minerals in the body; essential for the proper functioning of muscles, nerves, and the heart and is required in blood clotting and in the formation of bones. Electrolytes-Sodium: vital to normal body processes, including nerve and muscle function. Potassium: vital to cell metabolism and muscle function CO₂ (carbon dioxide, bicarbonate): helps to maintain the body's acid-base balance (pH)-Chloride helps to regulate the amount of fluid in the body and maintain the acid-base balance. Kidney Tests-BUN (blood urea nitrogen) waste product filtered out of the blood by the kidneys; conditions that affect the kidney have the potential to affect the amount of urea in the blood. Creatinine: waste product produced in the muscles; filtered out of the blood by the kidneys so blood levels are a good indication of how well the kidneys are working. A liver panel is a group of tests that are performed together to detect, evaluate, and monitor liver disease or damage. The liver is one of the largest organs in the body and is located in the upper right-hand part of the abdomen and behind the lower ribs. The liver metabolizes and detoxifies drugs and substances that are harmful to the body. It produces blood clotting factors, proteins, and enzymes, helps maintain hormone balances, and stores vitamins and minerals. Bile, a fluid produced by the liver, is transported through ducts directly to the small intestine to help digest fats or to the gallbladder to be stored and concentrated for later use. A variety of diseases and infections can cause acute or chronic damage to the liver, causing inflammation (hepatitis), scarring (cirrhosis), bile duct obstructions, liver tumors, and liver dysfunction. Alcohol, drugs, some herbal supplements, and toxins can also pose a threat. A significant amount of liver damage may be present before symptoms such as jaundice, dark urine, light-colored stools, itching (pruritus), nausea, fatigue, diarrhea, and unexplained weight

loss or gain emerge. Early detection is essential in order to minimize damage and preserve liver function. The liver panel measures enzymes, proteins, and substances that are produced or excreted by the liver and are affected by liver injury. Some are released by damaged liver cells and some reflect a decrease in the liver's ability to perform one or more of its functions. When performed together, these tests give the doctor a snapshot of the health of the liver, an indication of the potential severity of any liver injury, change in liver status over time, and a starting place for further diagnostic testing. In this instance, the treating physician has been ordering a chem 8, CBC, and liver panel roughly every 3 months and would like to continue the same. The testing has been repeatedly normal. The rationale for this kind of lab monitoring is not apparent. The ODG and MTUS are silent on routine blood work for those on chronic opioids. Consequently, a chem 8, liver panel, and CBC every 3 months for one is not medically necessary.