

<b>Case Number:</b>	CM15-0004260		
<b>Date Assigned:</b>	01/15/2015	<b>Date of Injury:</b>	02/13/2003
<b>Decision Date:</b>	03/20/2015	<b>UR Denial Date:</b>	01/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2015

### 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: Pennsylvania  
 Certification(s)/Specialty: Internal Medicine

### 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 60-year-old male, with a reported date of injury of 02/13/2003. The diagnoses include low back pain and lumbar and thoracic radiculitis, status post L4-5 discectomy, lumbar spondylosis, strain of lumbar spine, bilateral carpal tunnel syndrome, and myofascial pain syndrome/fibromyalgia. Treatments have included lumbar fusion at L4-5 and L5-S1 in 2007, chiropractic treatment, H-wave unit, oral pain medications. Work status was documented as permanently disabled in 2012 and 2014. Per information included in Agreed Medical Examinations, the injured worker has been prescribed Norco and oxycontin since 2007. Benzodiazepines have been prescribed at least since 2010. It was documented that in 2007, a physician noted the injured worker was obtaining opioids from more than one prescriber. Two urine drug screens in 2010 were noted to be inconsistent with prescribed medications. A urine drug screen in October 2014 was positive for three different benzodiazepines with notation that only one of these was prescribed. A urine drug screen in November 2014 was positive for four different benzodiazepines with notation that only one was prescribed, and negative for Norco which was inconsistent with prescribed medications. The progress report dated 12/17/2014 indicates that the injured worker had ongoing severe lower back pain. The physician noted that the injured worker's last drug test was negative for Norco but did not address the inconsistent result for benzodiazepines. The physician also noted that the injured worker admitted to taking more than the prescribed amount of oxycontin. The pain was located in the lumbar-sacral spine, in the left lower back area, in the midline of the lower back area and in the right lower back area. The injured worker rated his pain a 5 out of 10 in severity, with medications. The physical

examination of the lumbar spine showed tenderness at the lumbar spine, tenderness at the facet joint, decreased flexion, decreased extension, and decreased lateral bending. The treatment plan was to continue the current medication schedule, and to refill the medications. The physician documented that the injured worker was advised he needs to be adherent to the treatment plan otherwise he would need to be seen on a weekly basis, and that a red flag was given. The medical records provided for review included the reports for multiple urine drug tests performed during office visits. On 01/03/2015, Utilization Review (UR) denied the request for Norco 10/325mg #180, Ativan 1mg #90, one (1) urine drug screen, and one (1) assay of urine creatinine. The UR modified the request for OxyContin 20mg #60 and OxyContin 40mg #90. The UR physician noted that the injured worker was not taking Norco, no evidence of functional improvement, no indication to continue Ativan beyond guideline recommendations, and a repeat urine drug screen was not necessary on the date performed. The MTUS Chronic Pain Guidelines and the Non-MTUS Official Disability Guidelines were cited.

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

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

**Norco 10/325 mg, 180 count:** 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): 74-96.

**Decision rationale:** There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. The injured worker has been prescribed the opioids norco and oxycontin since 2007, with documentation of ongoing pain. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. Work status remains permanently disabled, and office visits have continued at the same frequency during 2013 and 2014. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain; change in activities of daily living, or discussion of adverse side effects. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. These should be random urine drug screens; the urine drug screens submitted were performed during office visits. In 2007, it was documented that the injured worker was found to be obtaining opioids from more than one prescriber. In 2010, two urine drug screens were inconsistent with prescribed medications. In 2014, the injured worker

had a urine drug screen which was negative for norco while norco was prescribed, which may suggest diversion, and positive for multiple benzodiazepines when only one was prescribed. The treating physician noted that the injured worker had taken more oxycontin than was prescribed. In spite of this, prescription for opioids and benzodiazepines continued. Due to lack of prescribing of opioids in accordance with MTUS, and documentation of ongoing aberrant drug-taking behaviors for several years, the request for Norco is not medically necessary.

**Oxycontin 20 mg, sixty count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Oxycontin and On-Going Management Sections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids  
Page(s): 74-96.

**Decision rationale:** There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. The injured worker has been prescribed the opioids norco and oxycontin since 2007, with documentation of ongoing pain. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. Work status remains permanently disabled, and office visits have continued at the same frequency during 2013 and 2014. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain; change in activities of daily living, or discussion of adverse side effects. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. These should be random urine drug screens; the urine drug screens submitted were performed during office visits. In 2007, it was documented that the injured worker was found to be obtaining opioids from more than one prescriber. In 2010, two urine drug screens were inconsistent with prescribed medications. In 2014, the injured worker had a urine drug screen which was negative for norco while norco was prescribed, and positive for multiple benzodiazepines when only one was prescribed. The treating physician noted that the injured worker had taken more oxycontin than was prescribed. In spite of this, prescription for opioids and benzodiazepines continued. Due to lack of prescribing of opioids in accordance with MTUS, and documentation of ongoing aberrant drug-taking behaviors for several years, the request for oxycontin 20 mg, sixty count is not medically necessary.

**Oxycontin 40 mg, ninety count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Oxycontin and On-Going Management Sections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

**Decision rationale:** There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. The injured worker has been prescribed the opioids norco and oxycontin since 2007, with documentation of ongoing pain. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. Work status remains permanently disabled, and office visits have continued at the same frequency during 2013 and 2014. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain; change in activities of daily living, or discussion of adverse side effects. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. These should be random urine drug screens; the urine drug screens submitted were performed during office visits. In 2007, it was documented that the injured worker was found to be obtaining opioids from more than one prescriber. In 2010, two urine drug screens were inconsistent with prescribed medications. In 2014, the injured worker had a urine drug screen which was negative for norco while norco was prescribed, and positive for multiple benzodiazepines when only one was prescribed. The treating physician noted that the injured worker had taken more oxycontin than was prescribed. In spite of this, prescription for opioids and benzodiazepines continued. Due to lack of prescribing of opioids in accordance with MTUS, and documentation of ongoing aberrant drug-taking behaviors for several years, the request for oxycontin 40 mg, ninety count is not medically necessary.

**Ativan 1 mg, ninety count with two refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines Page(s): 24.

**Decision rationale:** Per the MTUS, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long term use may actually increase anxiety. The MTUS does not

recommend benzodiazepines for long term use for any condition. The MTUS does not recommend benzodiazepines as muscle relaxants. The injured worker has been prescribed benzodiazepines since 2010. A urine drug screen in October 2014 was positive for three different benzodiazepines with notation that only one of these was prescribed. A urine drug screen in November 2014 was positive for four different benzodiazepines with notation that only one was prescribed. These findings are consistent with aberrant drug-taking behavior. The finding of multiple simultaneously ingested benzodiazepines, which is potentially toxic, was not addressed by the treating physician. Due to the prescription of ativan for longer than the recommended timeframe in the guidelines, and the finding on urine drug screens of multiple benzodiazepines which is potentially toxic and consistent with aberrant drug-taking behavior, the request for ativan is not medically necessary.

**One urine drug screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Substance Abuse (Tolerance, Dependence, Addiction) Section.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines drug testing 43, opioids 77- 78, 89, 94 Page(s): 43, 77-78, 89, 94. Decision based on Non-MTUS Citation chronic pain chapter, Urine drug testing

**Decision rationale:** Per MTUS chronic pain medical treatment guidelines, urine drug screens are recommended as an option to assess for the use or the presence of illegal drugs, in accordance with a treatment plan for use of opioid medication, and as a part of a pain treatment agreement for opioids. Per the ODG, 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. Urine drug testing is recommended at the onset of treatment when chronic opioid management is considered, if the patient is considered to be at risk on addiction screening, or if aberrant behavior or misuse is suspected or detected. Ongoing monitoring is recommended if a patient has evidence of high risk of addiction and with certain clinical circumstances. Frequency of urine drug testing should be based on risk stratification. Patients with low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at moderate risk for addiction/aberrant behavior should be tested 2-3 times per year. Patients at high risk of adverse outcomes may require testing as often as once a month. Random collection is recommended. Results of testing should be documented and addressed. The documentation indicates the injured worker had multiple episodes consistent with aberrant drug-taking behavior dating back to 2007. Multiple urine drug screens were inconsistent with prescribed medications, the physician documented that the injured worker admitted to taking more than the prescribed amount of oxycontin, and the most recent urine drug screen was negative for Norco, a prescribed medication, which may suggest diversion. Urine drug screens were performed at office visits, not at random times as recommended by the guidelines. The two most recent urine drug screens were performed in October and November of 2014. Because of the documentation of aberrant drug-taking behavior and lack of prescribing of opioids in accordance with the MTUS guidelines, the requests for opioids and benzodiazepine medication have been found to be not medically necessary. Due to the fact that the controlled substances have been determined to be not

medically necessary, and the lack of use of urine drug screens at random as is recommended by the guidelines, the request for one urine drug screen is not medically necessary.

**One assay of urine creatinine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Substance Abuse (Tolerance, Dependence, Addiction) Section.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines drug testing 43, opioids p. 77- 78, p. 89, p. 94 Page(s): p. 43, 77-78, 89, 94. Decision based on Non-MTUS Citation chronic pain chapter: urine drug testing

**Decision rationale:** Per MTUS chronic pain medical treatment guidelines, urine drug screens are recommended as an option to assess for the use or the presence of illegal drugs, in accordance with a treatment plan for use of opioid medication, and as a part of a pain treatment agreement for opioids. Per the ODG, 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. Urine drug testing is recommended at the onset of treatment when chronic opioid management is considered, if the patient is considered to be at risk on addiction screening, or if aberrant behavior or misuse is suspected or detected. If tampering is suspected, urine temperature, pH (a test for acidity, including that of urine, a body fluid), and creatinine concentration should be checked. The documentation indicates the injured worker had multiple episodes consistent with aberrant drug-taking behavior dating back to 2007. Multiple urine drug screens were inconsistent with prescribed medications, the physician documented that the injured worker admitted to taking more than the prescribed amount of oxycontin, and the most recent urine drug screen was negative for Norco, a prescribed medication, which may suggest diversion. Urine drug screens were performed at office visits, not at random times as recommended by the guidelines. The two most recent urine drug screens were performed in October and November of 2014. There was no documentation of suspicion of tampering with the sample collections. The request for continued opioids and benzodiazepines, and therefore for urine drug screen, has been found to be not medically necessary on the basis of lack of prescribing in accordance with MTUS and continued evidence of aberrant drug-taking behavior. As the urine drug screen is not medically necessary, the assay for urine creatinine is not medically necessary.