

<b>Case Number:</b>	CM15-0167984		
<b>Date Assigned:</b>	09/08/2015	<b>Date of Injury:</b>	10/24/2011
<b>Decision Date:</b>	10/07/2015	<b>UR Denial Date:</b>	08/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2015

### 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 was 50 year old male, who sustained an industrial injury on October 24, 2011. The injured current complaint on July 23, 2015, was neck, shoulder and low back pain. The injured worker was taking Tramadol for severe pain and Naproxen for inflammation. The injured worker was taking the medications as directed and tolerated them well. The pain was better with lying down, H-wave therapy and medications. The physical exam noted strength to the lower extremities as 5 out of 5. The sensation was intact but diminished on the left lateral leg. There was moderate tenderness in the left paraspinous muscles. There was diffuse tenderness with palpation at the anterior shoulders bilaterally. There was limited flexion, due to pain. The February 4, 2015 through May 28, 2015 progress, the injured worker admitted to alcohol use, but rarely. The urine toxicology testing of February 4, 2015 through July 23, 2015, noted the alcohol level was negative. The injured worker was diagnosed with degenerative lumbar or lumbosacral intervertebral disc, thoracic or lumbosacral neuritis or radiculitis, low back pain, cervical spine degeneration, shoulder pain, rotator cuff tendonitis and chronic pain. The injured worker's treatment plan consisted of Fetzima for depression, Trazodone for insomnia, TENS unit (transcutaneous electrical nerve stimulation unit), Voltaren XR for pain, Naproxen for pain, Tramadol for moderate to severe pain, Norco was tried in the past which helped the pain, but the injured worker became very constipated, psychiatric services and random toxicology laboratory studies. The treatment plan included RFA (request for authorization) for a high complex qualitative UDS by immunoassay an alcohol testing any method other than breath. The UR (utilization review) board denied the requested item, on August 17, 2015, due to there was no documentation of urine drug screening results or

alcohol results being inconsistent. Without aberrant behavior or sign of drug misuse or any other documentation indicating that the claimant was on anything other than at minimal risk for medication misuse. The medical necessity of the high complex qualitative UDS by immunoassay was not medically established or certified.

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

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

**High complex qualitative urine drug screen by Immunoassay method with alcohol testing, any method other than breath, DOS: 04/02/15: 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 opioids Page(s): 76-84.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states: 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. The California MTUS does recommend urine drug screens as part of the criteria for ongoing use of opioids. The patient was on opioids at the time of request however the need for alcohol screening is not established and the request is not

medically necessary.