Case Number:	CM15-0085719		
Date Assigned:	05/08/2015	**Date of Injury:**	03/26/2002
Decision Date:	06/16/2015	**UR Denial Date:**	04/22/2015
Priority:	Standard	**Application Received:**	05/04/2015

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 50 year old female who sustained an industrial injury on 3/26/02 when she was struck on the left forearm with a piece of wood and felt immediate pain in the area down to the left thumb. She was medically evaluated and received x-rays of her left elbow, wrist and forearm and treatment with Advil. She was diagnosed with a probable strain. She complained of tingling sensation in the forearm and wrist. She had further evaluations and physical therapy, rest and analgesics with muscle relaxants were recommended. The pain moved to the shoulder area, back and upper back. Diagnoses include causalgia of upper limb, complex regional pain syndrome, chronic pain syndrome, constipation, nausea, and unspecified adverse effects of medication. Additional medical history includes hypertension and gastroesophageal reflux disease. Treatments to date include stellate ganglion blocks, physical therapy, acupuncture, biofeedback, electrical stimulator, medication, hypnosis. Diagnostics include electromyography (5/21/02) normal, MRI of the left wrist and forearm which were normal, and bone scan which was normal. Medications in December 2012 included avinza, hydromorphone, ibuprofen, miralax, and omeprazole. At a visit in December 2012, the physician documented that there was no evidence of aberrant drug behavior, and noted that the injured worker has signed a narcotic agreement; urine drug testing was performed. It was noted that the injured worker was disabled. Visits in 2013 to 2015 note ongoing pain in the upper extremities, constipation and nausea secondary to medication, use of the same medications, and no aberrant drug related behavior. Urine drug screens were performed in June, September, and December 2013, March, June, September 2014, and January 2015 and were consistent. Skelaxin was added for muscle spasms

in February 2014. Multiple elevated blood pressure readings were recorded including blood pressure (BP) of 191/124 in 9/14, BP of 160/88 in 1/15, BP of 170/90 in 2/15, and BP of 160/100 in 3/15; these readings were not addressed. At a visit on 3/17/15, the injured worker complains of left wrist and bilateral arm pain, constipation and gastroesophageal reflux (GERD) but reports these are chronic in nature and moderately controlled with medication. Examination was unremarkable. The physician again documented that there was no evidence of aberrant behavior or drug abuse. Medications include Avinza, hydromorphone, ibuprofen, metaxalone, Milarax, and omeprazole. Lab panel to assess kidney and liver function was ordered and medications were refilled. On 4/22/15, Utilization Review (UR) non-certified requests for the items currently under Independent Medical Review, citing the MTUS, ODG, and National Guideline Clearinghouse.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Ibuprofen 600mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-73.

Decision rationale: This injured worker has chronic upper extremity pain. Ibuprofen has been prescribed for more than two years. The injured worker was noted to have gastroestophageal reflux disease (GERD) and hypertension, with history of hypertension and multiple elevated blood pressure readings documented. Per the MTUS, nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended as a second line treatment after acetaminophen for treatment of acute exacerbations of chronic back pain. The MTUS does not specifically reference the use of NSAIDs for long term treatment of chronic pain in other specific body parts. NSAIDs are noted to have adverse effects including gastrointestinal side effects and increased cardiovascular risk; besides these well-documented side effects of NSAIDs, NSAIDs have been shown to possibly delay and hamper healing in all the soft tissues including muscles, ligaments, tendons, and cartilage. NSAIDs can increase blood pressure and may cause fluid retention, edema, and congestive heart failure; all NSAIDS are relatively contraindicated in patients with renal insufficiency, congestive heart failure, or volume excess. They are recommended at the lowest dose for the shortest possible period in patients with moderate to severe pain. NSAIDs should be used for the short term only. Systemic toxicity is possible with NSAIDs. The FDA and MTUS recommend monitoring of blood tests and blood pressure. The March 2015 progress note states that tests of liver and kidney function were ordered, but there was no prior discussion of laboratory monitoring in the more than two years of use. The multiple elevated blood pressure readings were not addressed. The injured worker was consistently described as disabled, no return to work was documented, there was no discussion of improvement in activities of daily living or decrease in medication use, and office visits have continued at the same frequency. Due to lack of functional improvement, presence of GERD and significantly elevated blood pressure, and length of use in excess of the guidelines, the request for ibuprofen is not medically necessary.

1 prescription of Metaxalone 800mg #90: 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), Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines metaxalonemuscle relaxants Page(s): 61, 63-66.

Decision rationale: This injured worker has chronic upper extremity pain. Skelaxin (metaxalone) was prescribed since February 2014, with notation of the reason for use as muscle spasms. Recent physical examinations did not document presence of muscle spasm. The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Metaxalone is recommended with caution as a second line option for short-term pain relief in patients with chronic low back pain. It is reported to be relatively non-sedating. Side effects include dizziness and drowsiness, although less than compared to other skeletal muscle relaxants. Side effects include headache, nervousness, nausea, vomiting, and gastrointestinal (GI) upset. It should be used with caution in patients with renal and/or hepatic failure. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. No reports show any specific and significant improvement in pain or function as a result of prescribing this medication. The injured worker was consistently described as disabled, no return to work was documented, there was no discussion of improvement in activities of daily living or decrease in medication use, and office visits have continued at the same frequency. This injured worker was noted to have ongoing nausea, which is a noted side effect of metaxalone. There was no documentation of testing for renal and hepatic function. Due to lack of functional improvement, length of use in excess of the guidelines, and potential for toxicity, the request for metaxalone is not medically necessary.

1 prescription of Miralax powder oral #1 bottle: Overturned

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: Initiating Therapy [with opioids] Page(s): 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: opioid induced constipation treatment.

Decision rationale: The MTUS notes that when initiating therapy with opioids, prophylactic treatment of constipation should be initiated. Per the ODG, constipation occurs commonly in patients receiving opioids. If prescribing opioids has been determined to be appropriate, prophylactic treatment of constipation should be initiated. First line treatment includes increasing physical activity, maintaining appropriate hydration, and diet rich in fiber. Some laxatives may help to stimulate gastric motility, and other medications can help loosen otherwise hard stools, add bulk, and increase water content of the stool. This injured worker has been prescribed two opioid medications, avinza and hydromorphone; these medications were certified in the Utilization Review determination of 4/22/15. Miralax was non-certified in the Utilization Review determination, which stated that the injured worker was no longer certified for opioid therapy; this is inconsistent with the Utilization Review determination regarding avinza and hydromorphone. The physician progress notes document ongoing constipation. Per

the guidelines, laxatives are indicated when opioids are prescribed. As such, the request for miralax is medically necessary.

4 drug screen qual: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines drug testing, opioids Page(s): 43, 77-78, 89, 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 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. This injured worker has been prescribed chronic opioid therapy; a urine drug screening program is recommended by the guidelines. However, the documentation has consistently indicated that there was no evidence of addiction or aberrant behavior for this injured worker, and prior urine drug screens were all consistent with prescribed medications. Urine drug testing was performed three times in 2013, three times in 2014, and once in 2015 in January. This is in excess of the guideline recommendation of yearly testing for patients at low risk of addiction/aberrant behavior. There is no indication for another urine drug screen at the time of the current request which is only 3-4 months after the most recent testing. Due to frequency of testing in excess of the guidelines, the request for 4 drug screen qual is not medically necessary.

4 urine dip stick/ tablet: 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 NSAIDS, drug testing, opioids Page(s): 67-73, 43, 77-78, 89, 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: urine drug testing and Other Medical Treatment Guidelines UpToDate: Wald, Ron: Urinalysis in the diagnosis of kidney disease. In UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

Decision rationale: This request is for 4 urine dip stick/ tablet. Further details regarding this request were not provided by the treating physician. The specific testing to be performed using

urine dip sticks/tablets was not discussed. The urine dipstick provides a rapid semiquantitative assessment of urinary characteristics on a series of test pads embedded on a reagent strip. Most dipsticks permit the analysis of the following core urine parameters: heme, leukocyte esterase, nitrite, albumin, hydrogen ions (pH), specific gravity, and glucose. The physician documented plan to order testing of kidney and liver function. The current requests also include request for urine drug testing. This injured worker has chronic pain and has been prescribed chronic opioid medications, for which random urine drug testing is recommended by the guidelines. The injured worker has also been prescribed chronic nonsteroidal anti-inflammatory medication, for which testing of kidney function is recommended by the guidelines. Both of these uses for urine dip stick/tablets will be addressed. 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. Frequency of testing is determined by risk stratification for aberrant behavior. If tampering with a urine sample is suspected, urine temperature, pH (a test for acidity, including that of urine, a body fluid), and creatinine concentration should be checked. In this case, it was consistently documented that there was no aberrant behavior for this injured worker. There was no documentation of suspicion of tampering with a urine sample. In addition, the injured worker had a recent urine drug screen in January of 2015 which was consistent with prescribed medication; retesting in this time interval is not supported by the guidelines. If this request is presumed to be associated with the request for urine drug testing, as such it is not medically necessary. Regarding urine testing related to assessment of kidney function for this injured worker who has been prescribed ibuprofen for more than two years, such assessment is usually performed using blood testing for blood urea nitrogen and creatinine. The urinalysis is used in evaluating acute and chronic kidney disease, and can be used to monitor the course of kidney diseases in some patients. It may be used in patients with suspected kidney disease (on the basis of clinical findings or concurrent illness) or kidney stones, and in evaluation for urinary tract infection. This injured worker had no findings suggestive of acute or chronic kidney disease, urinary tract infection, or kidney stones. There was no documentation of the indication for performance of a urinalysis, and the submitted documentation did not include discussions of conditions for which a urinalysis (including use of urine dipstick) would be indicated. There was no discussion of the necessity for use of four urine dipsticks/tablets. Due to insufficiently specific prescription, and lack of specific indication, the request for 4 urine dip stick/ tablet is not medically necessary.

4 creatinine src: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Steps to avoid misuse/addiction. Decision based on Non-MTUS Citation National Clinical Guidelines Center, Chronic Kidney Disease, Early Identification and Management of Chronic Kidney Disease in Adults in Primary and Secondary Care. London (UK): National Institute for Health and Care Excellence (NICE); 2014 Jul. 59 p.

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

Decision rationale: This request for 4 creatinine src is consistent with urine testing for creatinine. The request for authorization notes this request is for testing four times per year. This request is consistent with testing in association with urine drug screening, which has been

requested for this injured worker who is on chronic opioid therapy. 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. If tampering is suspected, urine temperature, pH (a test for acidity, including that of urine, a body fluid), and creatinine concentration should be checked. In this case, the documentation has consistently indicated that there was no evidence of addiction or aberrant behavior for this injured worker, and prior urine drug screens were all consistent with prescribed medications. Urine drug testing was performed three times in 2013, three times in 2014, and once in 2015 in January. This is in excess of the guideline recommendation of yearly testing for patients at low risk of addiction/aberrant behavior. There is no indication for another urine drug screen at the time of the current request which is only 3-4 months after the most recent testing. There was no documentation of tampering to warrant testing of urine creatinine. Due to frequency of testing in excess of the guidelines, and lack of documentation of suspicion of tampering, the request for 4 creatinine src is not medically necessary.

4 ph body fluid nos: 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 drug testing, opioids Page(s): 43, 77-78, 89, 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: urine drug testing.

Decision rationale: This request for 4 ph body fluid nos is consistent with urine testing for pH. The request for authorization notes this request is for testing four times per year. This request is consistent with testing in association with urine drug screening, which has been requested for this injured worker who is on chronic opioid therapy. 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. If tampering is suspected, urine temperature, pH (a test for acidity, including that of urine, a body fluid), and creatinine concentration should be checked. In this case, the documentation has consistently indicated that there was no evidence of addiction or aberrant behavior for this injured worker, and prior urine drug screens were all consistent with prescribed medications. Urine drug testing was performed three times in 2013, three times in 2014, and once in 2015 in January. This is in excess of the guideline recommendation of yearly testing for patients at low risk of addiction/aberrant behavior. There is no indication for another urine drug screen at the time of the current request which is only 3-4 months after the most recent testing. There was no documentation of tampering to warrant testing of urine pH. Due to frequency of testing in excess of the guidelines, and lack of documentation of suspicion of tampering, the request for 4 ph body fluid nos is not medically necessary.

1 spectrophotometry: 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 drug testing, opioids Page(s): 43, 77-78, 89, 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: urine drug testing.

Decision rationale: This request for 1 spectrophotometry is consistent with testing performed with urine drug screening. 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. Typically, screening assays are based on immunoassays, which can be either laboratory-based or point-of-collection (POC) testing. Confirmatory testing for specific drug identification is laboratory-based and includes gas chromatography/mass spectrometry (GC/MS) or liquid chromatography tandem mass spectrometry (LC/MS/MS). 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. 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. This injured worker has been prescribed chronic opioid therapy; a urine drug screening program is recommended by the guidelines. However, the documentation has consistently indicated that there was no evidence of addiction or aberrant behavior for this injured worker, and prior urine drug screens were all consistent with prescribed medications. Urine drug testing was performed three times in 2013, three times in 2014, and once in 2015 in January. This is in excess of the guideline recommendation of yearly testing for patients at low risk of addiction/aberrant behavior. There is no indication for another urine drug

screen at the time of the current request which is only 3-4 months after the most recent testing. Due to frequency of testing in excess of the guidelines, the request for 1 spectrophotometry is not medically necessary.

1 random toxicology: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines drug testing, opioids Page(s): 43, 77-78, 89, 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 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. This injured worker has been prescribed chronic opioid therapy; a urine drug screening program is recommended by the guidelines. However, the documentation has consistently indicated that there was no evidence of addiction or aberrant behavior for this injured worker, and prior urine drug screens were all consistent with prescribed medications. Urine drug testing was performed three times in 2013, three times in 2014, and once in 2015 in January. This is in excess of the guideline recommendation of yearly testing for patients at low risk of addiction/aberrant behavior. There is no indication for another urine drug screen at the time of the current request which is only 3-4 months after the most recent testing. Due to frequency of testing in excess of the guidelines, the request for 1 random toxicology is not medically necessary.