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| <b>Case Number:</b>   | CM14-0183017 |                              |            |
| <b>Date Assigned:</b> | 11/07/2014   | <b>Date of Injury:</b>       | 06/15/2006 |
| <b>Decision Date:</b> | 12/17/2014   | <b>UR Denial Date:</b>       | 10/23/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/03/2014 |

### 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 Internal Medicine and is licensed to practice in New York. 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 patient is a 55 year old male teacher working in a prison with a date of injury of 06/15/2006. He was going up a set of stairs, tripped and fell forward. His knees hit the concrete steps. On 05/30/2007 he had left knee arthroscopic surgery and on 12/06/2007 he had right knee arthroscopic surgery. He returned to work and had bilateral knee pain. On 09/10/2009 he had an arthroscopic right knee ACL reconstruction. He returned to work in 05/2010. On 08/11/2012 he had an essentially normal knee examination - no instability, no effusion, no thigh atrophy, patella tracks normally, good alignment, with a range of motion that is limited in flexion of only 10 degrees. The diagnosis was maladaptive pain syndrome. It was noted that office visits were too frequent since the "frequency of visits does nothing to the good other than to establish and maintain the perception of significant disability." On 05/13/2013 a hydrocodone prescription was filled. In 06/2013 he stopped working. He uses a front wheeled walker. On 08/22/2013 he was using a walker and bilateral knee sleeves. He weighed 191 pounds. On 10/10/2013 a prescription for Diclofenac was filled. On 11/05/2013 his medication included Voltaren and Neurontin. He was also taking medication for diabetes and hypertension. He used a front wheeled walker. Knee range of motion was limited by pain. He had a "very overt demonstration of difficulty" getting up from a chair. He was to start aquatic therapy. On 01/31/2014 he had a MRI of his left knee. He had post-operative changes. There was no tear of ligament or meniscus. There was mild degenerative change. On 02/04/2014 he had a MRI of the right knee. There was mild degenerative change. There were post-operative changes. The medial collateral ligament may be sprained or partially torn near the femoral attachment. He had an office visit on 03/12/2014. Palpation of the knee anteriorly and laterally was associated with tenderness. He had a steroid injection to each knee. The most recent prescription filled for hydrocodone was on 05/13/2013. On 03/20/2014 it was again noted that there was a wide divergence between his symptoms

versus findings on exam and imaging. He was now on narcotic medication which he was not taking previously when examined by the same person previously. The diagnosis was again maladaptive pain syndrome. He was also taking Avinza (opiate/morphine). On 04/11/2014 a urine test was appropriately positive for opiate but also for Ecstasy. Hydrocodone was negative. On 06/06/2014 it was noted that the urine drug screen was "consistent with what he is taking." On 08/08/2014 the urine drug test was only positive for opiates and was consistent with taking Avinza. Ecstasy was negative. On 08/12/2014 Ecstasy was again positive, methadone metabolite was positive and opiate was negative. Methadone had been prescribed.

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

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

**Urine drug screen (Date of service: 4/15/14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-80. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter (updated 7/10/14), Criteria for the use of Urine Drug Testing

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-going Management Page(s): 78 - 79.

**Decision rationale:** According to Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 78, 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 nonadherent) 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. He never met MTUS criteria for on-going opiates. The frequent office visits, opiates and urine testing contributed to his "maladaptive pain syndrome" and simply ignoring two urine tests that were positive for Ecstasy suggests that urine testing was not medically necessary to manage this patient.

**Urine drug screen (Date of service: 6/6/14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-80. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter (updated 7/10/14), Criteria for the use of Urine Drug Testing

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-going Management Page(s): 78 - 79.

**Decision rationale:** According to Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 78, 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 nonadherent) 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. He never met MTUS criteria for on-going opiates. The frequent office visits, opiates and urine

testing contributed to his "maladaptive pain syndrome" and simply ignoring two urine tests that were positive for Ecstasy suggests that urine testing was not medically necessary to manage this patient.

**Urine drug screen (Date of service: 8/12/14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-80. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter (updated 7/10/14), Criteria for the use of Urine Drug Testing

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78 - 79.

**Decision rationale:** According to Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 78, 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 nonadherent) 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. He never met MTUS criteria for on-going opiates. The frequent office visits, opiates and urine testing contributed to his "maladaptive pain syndrome" and simply ignoring two urine tests that were positive for Ecstasy suggests that urine testing was not medically necessary to manage this patient.