

<b>Case Number:</b>	CM14-0091627		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	09/15/2003
<b>Decision Date:</b>	06/12/2015	<b>UR Denial Date:</b>	06/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/17/2014

### 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. 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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 58 year old male who sustained an industrial injury on 09/15/2003 when an excavator arm swung and hit the injured worker on the left side of the body throwing him off a deck for a distance of approximately 22 feet with momentary loss of consciousness. The injured worker was diagnosed with osteoarthritis C6-7, musculoligamentous sprain of the cervicothoracic spine, acromioclavicular impingement and osteoarthritis of the left shoulder, musculoligamentous sprain of the lumbosacral spine, lumbar spine degenerative disc disease, osteoarthritis and musculoligamentous sprain of the left hip and internal derangement left knee. The injured worker is status post L4-5 micro decompression in May 2004. Treatment to date includes multiple diagnostic testing, surgery, epidural steroid injection (ESI), physical therapy, lumbar, elbow and wrist braces, a cane for ambulation and medications. According to the primary treating physician's progress report on April 21, 2014, the injured worker continues to experience neck and low back pain, bilateral shoulder, elbow, wrist and left knee pain. The injured worker rates his cervical pain level at 8-10/10 depending on movement with numbness and tingling to both arms and hands but mostly on the left side. The injured worker rates his left shoulder pain level at 4.5-5 /10 and some days up to 10/10 numbness and tingling into the left hand. The injured worker rates his lower back pain level at 9.5-10/10 with radiation, numbness and tingling to the left foot. He reports popping in the left knee with a daily pain level of 8/10. Current medications are listed as Tramadol, Norco and Naproxen. Treatment plan consists of baseline qualitative urine drug screening, medications and unknown frequent random urine toxicology screens and unknown prescription of Norco.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Unknown Frequent Random Urine Toxicology Screens:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opiates, steps to avoid misuse/addiction.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Urine Drug Screen.

**Decision rationale:** 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 injured worker 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 injured worker asks for a specific drug. This is particularly the case if this drug has high abuse potential, the injured worker refuses other drug treatment and/or changes in scheduled drugs, or refuses generic drug substitution. (3) If the injured worker 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. See Opioids, indicators for addiction & misuse. Ongoing monitoring: (1) If a injured worker 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. See Opioids, tools for risk stratification & monitoring. (2) If dose increases are not decreasing pain and increasing function, consideration of UDT should be made to aid in evaluating medication compliance and adherence. According to the documents available for review, the injured worker meets none of the aforementioned MTUS criteria for the use of urine drug testing. Further, the current request lacks a specified frequency. Therefore at this time the requirements for treatment have not been met, and the request is not medically necessary.

### **Unknown Prescription of Norco:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid  
Page(s): 74-97.

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines section on Opioids, On-Going Management, p 74-97, (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 injured worker'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 injured worker'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 injured workers 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 injured worker 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 in injured worker 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. Additionally, the MTUS states that continued use of opioids requires (a) the injured worker has returned to work, (b) the injured worker has improved functioning and pain. The current request lacks a dose, frequency and total number of pills to be dispensed as required by the MTUS above. Therefore, at this time, the requirements for treatment have not been met and the request is not medically necessary.