MAXIMUS Federal Services

Case Number:	CM15-0127325		
Date Assigned:	07/14/2015	Date of Injury:	04/24/2007
Decision Date:	08/07/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/01/2015

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 is a 60 year old male, who sustained an industrial injury on 4/24/07. Initial complaints were sharp low back pain with radiation down the left leg. The injured worker was diagnosed as having lumbosacral neuritis NOS; lumbar/lumbosacral disc degeneration; lumbosacral spondylosis; sprain lumbar region; thoracic disc displacement; chronic pain NEC; sprain shoulder/arm NOS; sprain thoracic region; lumbar disc displacement; post-surgical states NEC; organic brain syndrome NOS; depressive psychosis-moderate; psychogenic pain NEC; anxiety state NOS; opioid dependence-unspecified; lumbar disc displacement with myelopathy; disc degeneration with myelopathy NOS; chronic pain. Treatment to date has included epidural steroid injections; radiofrequency ablations; status post spinal cord stimulator implant (6/8/2009); physical therapy; urine drug screening; medications. Diagnostics studies included MRI lumbar spine (5/14/15); EMG/NCV study bilateral lower extremities (6/2/15). Currently, the PR-2 notes dated 5/19/15 indicated the injured worker is in the office for a re-evaluation and was last seen on 4/14/15. The provider notes a detailed clinical history for his lumbar pain. Objective findings are documents as a stiff antalgic wide-based gait. His lumbar examination of the posterior lumbar musculature reveals tenderness to palpation bilaterally with increased muscle rigidity. There are numerous trigger points that are palpable and tender throughout the lumbar paraspinal muscles. He has decreased range of motion with obvious muscle guarding. His sensory examination with pinprick wheel was decreased along with anterior lateral thighs and medial calves bilaterally. There is global motor weakness all over. The straight leg raise in the modified sitting position is positive bilaterally at 60 degrees. A lumbar spine MRI dated

5/14/15 is documented in the provider's notes revealing advanced multilevel lumbar spondylosis from T12-S1 with grade I spondylolisthesis at l4-5 with multilevel moderate to severe central and bilateral foraminal stenosis, left greater than right with associated ligamentum flavum and facet hypertrophy. A lower extremity EMG/NCV was performed on 4/22/15 revealing an acute L5 radiculopathy. The provider documents the injured worker has severe central bilateral foraminal stenosis with resultant bilateral lower extremity radiculopathy and neurogenic claudication. He has extensive pathology throughout his lumbar spine and wanted to avoid surgery several years ago. He trailed a spinal cord stimulator which gave him excellent results. Unfortunately, the permanent spinal cord stimulator was not that effective. Eventually, another provider removed the stimulator for the injured worker. In review of the most recent MRI and EMG, the provider documents the injured worker's radicular pattern is mixed and seems to involve nerve roots throughout the lumbar spine with a sensory loss, lack of reflexes and global motor weakness. His treatment plan includes a surgical consult for evaluation. The provider is requesting authorization of Retrospective request for date of service (DOS): 04/14/15 for a U/A drug screen, Chromatography.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for date of service (DOS): 04/14/15 for a U/A drug screen, Chromatography: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Urine Drug Testing.

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 dairy 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 nonopioid 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 and therefore the request is medically necessary.