

Case Number:	CM15-0177541		
Date Assigned:	09/18/2015	Date of Injury:	03/16/2013
Decision Date:	11/13/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/09/2015

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: California

Certification(s)/Specialty: Emergency 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:

This 30-year-old male sustained an industrial injury on 3-16-13. Documentation indicated that the injured worker was receiving treatment for low back pain with bilateral radicular pain. Previous treatment included physical therapy, epidural steroid injections, transcutaneous electrical nerve stimulator unit and medications. Electromyography and nerve conduction velocity test of bilateral lower extremities (5-4-15) was normal. In a pain management evaluation dated 3-3-15, the injured worker reported that left lower extremity pain had improved following left L4-5 and L5-S1 epidural steroid injection on 2-11-15. The physician noted that magnetic resonance imaging lumbar spine showed a "relatively" large disc herniation at L3-4 and L4-5 and spondylolisthesis at L5-S1. Physical exam was remarkable for lumbar spine with "some" tenderness to palpation with palpable muscle spasms and "decreased" range of motion and positive bilateral straight leg raise. The physician stated that the injured worker was stable on his current medications. The injured worker had been on Fentanyl 75mcg in the past with side effects. The treatment plan included continuing medications (Mobic, Soma, Fentanyl patch and Norco). In a PR-2 dated 8-4-15, the injured worker complained of ongoing low back with radiation down both lower extremities to the feet, rated 8 out of 10 on the visual analog scale, associated with occasional numbness and tingling as well as left calf cramping. The injured worker stated that his left lower extremity pain remained reduced by about 60% after 2-11-15 epidural steroid injection. The injured worker stated that medications decreased his pain from 8 out 10 to 5 out of 10, providing "substantial" assistance with activities of daily living, mobility and restorative sleep. Physical exam was remarkable for tenderness to palpation at the sciatic notch, range of motion: left lateral flexion 15 degrees, right lateral flexion 20 degrees, left rotation 20 degrees, right rotation 30 degrees, flexion 30 degrees and extension 10 degrees and pain upon range of motion. The injured worker walked

with a normal gait without the use of an assistive device. The physician stated that previous urine drug screen tests had been consistent with prescriptions. The injured worker had signed a pain management agreement that was updated on 8-4-15. The treatment plan included requesting authorization for a knee wedge pillow, random routine drug screen, follow-up office visit, re-evaluation every 90 days and medications (Mobic, Soma, Fentanyl patch and Norco). On 8-18-15, Utilization Review non-certified a request for Soma 350mg 2-3 times daily as needed for spasms and in-office urine drug screen done on 8-11-15. Utilization Review modified Fentanyl 25mcg per hour every 48 hours to Fentanyl 25mcg per hour every 48 hours #8 and Norco 10-325mg 4-5 times daily as needed for breakthrough pain to Norco 10-325mg 4-5 times daily as needed for breakthrough pain #84.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg 2-3 times a daily as needed for spasms quantity 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate documentation of a recent acute exacerbation and poor effectiveness for chronic long-term use, the request is not medically necessary.

Fentanyl 25 mcg/hour patches every 48 hours quantity 15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement seen. As such, the request is not medically necessary. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome. A modified certification has been approved for weaning.

Norco 10/325mg 4-5 times daily as needed for breakthrough pain quantity 150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement seen. As such, the request is not medically necessary. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome. A modified certification has been approved for weaning.

In-Office Urine Drug Screen: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic)/Urine drug testing (UDT).

Decision rationale: The request is for a urine drug screen. The ODG states the following regarding this topic: 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 patient 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 patient asks for a specific drug. This is particularly the case if this drug has high abuse potential, the patient refuses other drug treatment and/or changes in scheduled drugs, or refuses generic drug substitution. (3) If the patient has a positive or "at risk" addiction screen on evaluation. This may also include evidence of a history of co-morbid 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 patient has evidence of a "high risk" of addiction (including evidence of a co-morbid 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. In this case, a urine drug screen is supported by the guidelines. Ongoing monitoring with a urine drug screen is appropriate due to a higher risk level of abuse in this case. As such, it can be performed more frequently if the practitioner requests it. Therefore, the request for In-Office Urine Drug Screen is medically necessary.