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| <b>Case Number:</b>   | CM15-0177951 |                              |            |
| <b>Date Assigned:</b> | 09/18/2015   | <b>Date of Injury:</b>       | 10/09/2012 |
| <b>Decision Date:</b> | 10/21/2015   | <b>UR Denial Date:</b>       | 08/14/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 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: 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 59 year old female, who sustained an industrial injury on 10-9-12. The injured worker was diagnosed as having lumbar spinal stenosis; lumbar radiculitis. Treatment to date has included physical therapy; medications. Diagnostics studies included CT myelogram (2-17-15). Currently, the PR-2 notes dated 4-1-15 indicated the injured worker was in the office as a follow-up appointment. The injured worker is a status post partial laminectomy L2 and L4, a total laminectomy at L3 on 3-20-15. She was a status post previous lumbar anterior-posterior fusion at L4-5 in 2010. She reported her pain was stable until her industrial injury in 2012. The provider documents "The patient is continuing to use Butrans Patch 10mcg-hr and Norco 10-325mg twice a day to 4 times a day. She does continue to feel that these medications are helpful and allow her to remain functioning including working modified duty. She would like a refill on these today. She did state that her wound dehiscd and she had to have the surgeon staple her wound and she is now on antibiotics." The provider continues documentation noting, "The patient rates her low back pain as 3-8 out of 10 in intensity with pain medications. She has increased pain with repetitive bending, stooping, and with prolonged sitting, standing and walking. She feels that lying down and medications are helpful for her pain." The provider notes she is in no acute distress and no evidence of overmedication or sedation. The provider discussion and treatment plan notes the injured worker completed the opioid risk tool on 2-12-14 and she scored "0" indicating low risk. The provider also documents he obtained the "CURES report on 3-27-15 and "it was consistent with history". He is refilling her medications for Norco 10-325mg BID #60 and her Butrans 10mcg 1 patch every 7 days #4. A Request for

Authorization is dated 9-9-15. A Utilization Review letter is dated 8-14-15 and modified-certification was for retrospective high complexity qualitative urine drug screen by immunoassay method x 9 (date of service 04-01-2015) allowing 1 unit only instead of the requested 9 units and non-certification was for retrospective alcohol testing/ any method other than breath (date of service 04-01-2015). Utilization Review denied the treatments as requested for not meeting the CA MTUS Guidelines. The provider is requesting authorization of Retrospective high complexity qualitative urine drug screen by immunoassay method x 9 (date of service 04-01-2015) and Retrospective alcohol testing/ any method other than breath (date of service 04-01-2015).

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

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

#### **Retrospective high complexity qualitative urine drug screen by immunoassay method x 9 (DOS 04/01/2015): Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC Pain Procedure Summary last updated 07/10/2014.

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

**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 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. 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.

**Retrospective alcohol testing/ any method other than breath (DOS 04/01/2015): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC Pain Procedure Summary last updated 07/10/2014.

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

**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 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. The California MTUS does recommend urine drug screens as part of the criteria for ongoing use of opioids. However, the need for alcohol testing is not established as there is no evidence of alcohol abuse or aberrant behavior to justify this is addition to a standard UDS. Therefore, the request is not medically necessary.