

Case Number:	CM15-0179542		
Date Assigned:	09/21/2015	Date of Injury:	09/20/2001
Decision Date:	11/12/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/11/2015

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:

The injured worker is a 73 year old male, who sustained an industrial injury on September 20, 2001. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar failed back syndrome. On August 18, 2015, the injured worker reported thoracic back pain. The Treating Physician's report dated August 18, 2015, noted the injured worker was not as physically active as he previously was, with most of his time lying down, noting pain and some numbness in his back. The injured worker reported at least 50% pain relief with his medications. The injured worker was noted to have chronic thoracic back pain and failed back surgery syndrome with spinal cord stimulator (SCS) with declining functionality. Prior treatments have included a spinal cord stimulator (SCS), physical therapy, acupuncture, lumbar surgeries, and medications. The treatment plan was noted to include medications refilled as the injured worker showed increased activities of daily living (ADLs) with pain medication, a CURES, requested authorization for aquatic pool therapy, physical therapy, toxicology testing, and medications including Fentanyl patch, noted to be prescribed since at least February 2014, Meloxicam, noted to be added on March 16, 2015, and Norco, noted to be prescribed since at least February 2014. The request for authorization dated August 18, 2015, requested pool therapy, urine drug screen, and Norco 5/325 mg Qty 60, Fentanyl 25 mcg Qty 10, and Meloxicam 15 mg Qty 30. The Utilization Review (UR) dated August 26, 2015, modified the request for 12 sessions of pool therapy to certification of 6 sessions of pool therapy, non-certified the requests for a urine drug screen and Norco 5/325 mg Qty 60, modified the request for Fentanyl 25 mcg Qty 10 to certification of #5, and certified the request for Meloxicam 15 mg Qty 30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pool therapy, 12 sessions: 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): Aquatic therapy.

Decision rationale: The request is for aquatic therapy. The MTUS states the following regarding this topic: Recommended as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. For recommendations on the number of supervised visits, see Physical medicine. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. (Tomas-Carus, 2007) In this case, there is sufficient documentation to justify this therapy. As stated above, aquatic treatment is indicated when reduced weight bearing is desirable, as it minimizes the effects of gravity. At issue is the number of treatments. Since the patient has previously not undergone a trial of physical therapy, 6 initial treatments would be indicated. If there are signs of functional improvement seen, further therapy is indicated as such, the request is not medically necessary based on the number of treatments requested.

Norco 5/325 mg Qty 60: 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. The patient has actually shown a decline in function. As such, the request is not medically necessary. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome.

Fentanyl 25 mcg Qty 10: 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 the patient has shown a reduction in activity level. As such, the request is not medically necessary. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome.

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain (chronic) - Urine drug testing (UDT).

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. State and local laws may dictate the frequency of urine drug testing. 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 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 patient 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. The frequency of drug testing is indicated below: Patients at low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. Patients at moderate risk for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. This includes patients undergoing prescribed opioid changes without success, patients with a stable addiction disorder, those patients in unstable and/or dysfunction social situations, and for those patients with comorbid psychiatric pathology. Patients at high risk of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders. In this case, a urine drug screen is not supported by the guidelines. This is secondary to non-certification of continued opiate use making further drug screen unnecessary. As such, it is not medically necessary.