

<b>Case Number:</b>	CM13-0068326		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	07/17/2013
<b>Decision Date:</b>	05/29/2014	<b>UR Denial Date:</b>	11/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 49 year old male who was injured on 07/17/2013. He sustained an injury to his cervical spine. Prior treatment history has included OxyContin, Viramune, Epzicom and AndroGel. The patient underwent a C7-T1 interlaminar epidural steroid injection with catheter; fluoroscopic guidance/localization of needle/catheter for spine; interpretation for spine myelogram; and prolonged services on 11/08/2013. Evaluation note dated 10/30/2013 reports the patient has frequent neck pain which is located on the right side of the neck. The patient pain radiates to the bilateral upper extremities. The patient indicates that the character of the pain is sharp, burning, shooting, numbness and with pressure. The patient rates the current pain level at 8/10. The patient states the pain is relieved by medications and taking a break. The patient has peripheral neuropathy. The patient denies the recent discontinuation of treatment for illness. The patient denies drug use. Objective findings on exam revealed tenderness and hypertonicity upon palpation of the cervical paravertebral muscles. There is decreased cervical range of motion exhibiting flexion to 45; extension to 50; right rotation to 60; left rotation to 65; right lateral bending to 35; and left lateral bending to 30. Shoulder depression is positive bilaterally; cervical compression is positive bilaterally. Deep tendon reflexes are 2+/-4 bilaterally. The sensory examination reveals diminished sensation to light touch in the C6 nerve root distribution of the bilateral upper extremities. Diagnoses are cervical disc protrusion and brachial neuritis or radiculitis. The patient was given Norco 10/325 and a cervical spine epidural steroid injection at C5-6. The patient has failed conservative treatment (including drug therapy, activity modifications, and/or physical therapy) has documented radicular symptoms and findings. A qualitative drug screen was administered to the patient.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE REQUEST FOR 1 QUALITATIVE URINE DRUG SCREEN (DOS 10/30/2013): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, 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), CRITERIA FOR USE OF URINE DRUG TESTING, URINE DRUG TESTS.

**Decision rationale:** ODG Guidelines in reference to frequency of urine drug testing state that testing should be based on documented evidence of risk stratification including use of a testing instrument. An explanation of "low risk," "moderate risk," and "high risk" of addiction/aberrant behavior is found under opioids, tools for risk stratification & monitoring and opioids, screening tests for risk of addiction & misuse. 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. This patient appears to be low risk and therefore this testing is not medically necessary per the above guidelines. It appears he was not on opioids at this time and no suspicion of opioid abuse was documented. Therefore, this was not medically necessary.