

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM14-0002357 |                              |            |
| <b>Date Assigned:</b> | 03/03/2014   | <b>Date of Injury:</b>       | 11/01/2001 |
| <b>Decision Date:</b> | 06/16/2014   | <b>UR Denial Date:</b>       | 12/26/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/07/2014 |

### 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 Orthopedic Surgery and is licensed to practice in Texas. 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 44 year old male injured on 11/01/01 due to undisclosed mechanism of injury. Neither the specific injury sustained nor the initial treatments rendered were addressed in the clinical documentation submitted for review. Current diagnoses included two level significant lumbar discopathy with disc space narrowing. The patient received routine evaluations for ongoing complaints of low back pain and sleeping issues. Clinical note dated 02/12/14 indicated the patient presented with complaints of aching and stabbing low back pain rated at 10/10. Medication management included Norco, Ambien, Xanax, and topical analgesics. The patient underwent quarterly urine drug screens with intermittent inconsistencies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE REVIEW FOR DRUG-SCREEN WITH A DATE OF SERVICE OF 3/7/13:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines DRUG SCREENING.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

**Decision rationale:** As noted on page 43 of the Chronic Pain Medical Treatment Guidelines, urine drug screen is recommended as an option to assess for the use of or the presence of illegal drugs. The patient underwent quarterly testing to establish the presence or potential for dependence or diversion of medications. Previous inconsistencies with urine drug screens further necessitated routine urine drug screens. As such the request for retrospective review for drug screen with date of service of 03/07/13 is medically necessary.