

<b>Case Number:</b>	CM14-0002668		
<b>Date Assigned:</b>	01/29/2014	<b>Date of Injury:</b>	05/19/2013
<b>Decision Date:</b>	06/19/2014	<b>UR Denial Date:</b>	12/11/2013
<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 Orthopaedic Surgery and is licensed to practice in Mississippi. 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 record notes a 25-year-old female with an injury that dates back to May 2013. The mechanism of injury is not disclosed. A progress note from December 2013 is provided for review in support of the above noted request indicating that the claimant is status post right wrist surgery and continues to experience pain and swelling. The pain on the date of this evaluation is rated 7/10 on the visual analog scale (VAS). Pain with movement of the fingers is noted. A complaint of depressive symptoms is also noted, secondary to pain. A reference of suicidal ideation in the past is noted that without any current plans of self harm. The record indicates the Percocet is currently being utilized in the postoperative period, and that the claimant has discontinued the Tramadol. Ducosate has been provided, and does not control her constipation symptoms. Anti-inflammatory medications that were discussed at the last visit were discontinued by the claimant. The physical examination reveals the claimant to be in a splint with an ace bandage on the right wrist. A formal request for psychology consultation is noted. The diagnosis is pain in joint, forearm. This encounter note indicates that the claimant was provided, Percocet, by another physician, whose note is also provided for review. The date of that encounter note is November 1, 2013, at which point a surgical recommendation was made. The only other progress note available that precedes the urine drug screening under review is dated November 6, 2013. This encounter note indicates the claimant presents for follow-up. Right wrist pain is reported, and the claimant continues to utilize wrist and elbow braces. The record indicates radiation of pain into the right shoulder. The claimant is scheduled for surgery on November 27, 2013. The medications that the claimant is receiving from another physician are noted to be, Relafen, omeprazole, and terocin topical lotion. Dizziness and blood in stools is reported. Additionally, a notation is made of that since the last visit. The claimant has been experiencing low back pain with radiation to the posterior aspect of the left lower extremity to

the knee. Objective findings note only a normal general appearance, normal, ambulation, and that the claimant is wearing a right wrist in the right elbow brace. The current diagnosis is reported as joint pain, forearm. The current medications are naproxen, proton acts, and Ultracet. The naproxen is discontinued. The treatment recommendation is for the claimant to follow up with her primary care physician regarding the blood in stool and the new complaint of low back pain. A notation is made that no other changes in medications were made in the medications were refilled. Follow-up in 4 weeks is recommended. The two progress notes preceding the urine drug screen and the one progress note following the urine drug screen do not reference a necessity for urine drug screen, or any clear clinical indication in the medical record of the purpose of the screening. However, the record does indicate that the claimant is currently on Ultracet, which contains Tramadol, and is considered an opiate derivative. A prior review indicates that a urine drug screening was performed within 90 days prior to the urine drug screen and review. Furthermore, the medical records prior to November 1 was not available for review; therefore, a urine drug screen was obtained within 90 days of this request was not confirmed. A prior review of this request resulted in a recommendation for non-certification on December 11, 2013.

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

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

#### **RETROSPECTIVE REQUEST FOR URINE DRUG TESTING PERFORMED ON 11/18/13: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

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

**Decision rationale:** The MTUS guidelines support the use of urine drug screening as part of ongoing chronic opioid management. When noting the claimant's multiple medications, which includes Ultram, containing Tramadol, a synthetic opioid that does have abuse potential, as well as the clinical presentation, which includes a notation of depressive symptoms and a history of suicidal ideation, there is a clinical indication for the use of urine drug screening for the management of this individual's pain. Therefore, this request is certified. However, it should be noted, that a prior review references a urine drug screen that was obtained within 90 days of this request. Such clinical documentation is not available for this review. The guidelines recommendations support physician judgment in drug testing in the chronic pain setting, with recommendations for one to 2 times yearly. Based on the information available to me, which does not include medical records prior to November 1, 2013, this request is recommended for certification.