

Case Number:	CM14-0104524		
Date Assigned:	07/30/2014	Date of Injury:	03/19/2013
Decision Date:	10/03/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/07/2014

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 Family 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:

This machine operator reported injuries to his face, head and ears after an explosion that occurred 2 feet from his face on 3/19/13. He felt something strike his face, lost consciousness, and awoke on the ground 5-6 feet from where he had been. Current diagnoses include craniofacial injury, traumatic brain injury, post traumatic head syndrome, craniocervical headaches, cervical sprain, post traumatic labyrinthine concussion. Treatment has included physical therapy, chiropractic manipulation and acupuncture. The patient was already taking Effexor, quetiapine and temazepam for a previous diagnosis of PTSD (military service related) at the time of his first evaluation with his primary treater on 1/27/14. Beginning 2/28/14 the progress notes contain documentation of medications which were presumably dispensed, including "Voltaren 100" and "cyclo/keto/lido", which usually indicates a topical compounded cream. There is no documentation of any opioid being prescribed or dispensed. The primary treater is a physiatrist, and the patient is also seeing a neurologist/psychiatrist. The documentation of the initial evaluation of both these providers is available in the records. Neither documented any past history of drug abuse or concern for aberrant drug behavior. There is a 6/6/14 progress note from the primary treater's clinic which is signed by a PA. It documents that the patient is improving and has minimal pain, though he has some residual dizziness. A minimal physical/cognitive exam is documented as entirely normal. The plan includes discontinuing Voltaren and cyclo/keto/lido, and performing a urine drug screen (UDS). There is no rationale given or attached for the UDS. The records contain the results of a previous UDS performed 1/27/14. It is reported as "inconsistent" because it is positive for Effexor and Effexor metabolites, which the patient is not documented as taking. (The request for this screen contains no documentation of any medication.) The results of this test are not commented on in any of the available subsequent records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77-80 and 94. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Therapeutic Trial of Opioids, Opioids, Ongoing Management, Opioids, S. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Section, Urine Drug Testing, criteria for use

Decision rationale: Per the MTUS guidelines cited above, an assessment of the likelihood for substance abuse should be made before a therapeutic trial of opioid use is begun. The section on ongoing management of opioid use recommends that regular assessment for aberrant drug taking behavior should be performed. Drug screens should be used in patients with issues of abuse, addiction or poor pain control. The section on steps to avoid misuse/addiction recommends frequent random urine toxicology screens. Per the ODG reference cited, clinicians should be clear on the indication for using a UDS prior to ordering one. Testing frequency should be determined by assessing the patient's risk for misuse, with low-risk patients to receive random testing no more than twice per year. Documentation of the reasoning for testing frequency, need for confirmatory testing, and of risk assessment is particularly important in stable patients with no evidence of risk factors or previous aberrant drug behavior. Standard drug classes should be included in the testing, including cocaine, amphetamines, opiates, oxycodone, methadone, marijuana, and benzodiazepines. Others may be tested as indicated. A complete list of all drugs the patient is taking, including OTC and herbal preparations must be included in the request accompanying the test, as well as documentation of the last time of use of specific drugs evaluated for. Random collection is preferred. Unexpected results (illicit drugs, scheduled drugs that were not prescribed, or negative results for a prescribed drug) should be verified with GCMS. The clinical findings in this case do not support the performance of a UDS. This patient is not documented as taking an opioid, which would make drug testing unnecessary. Even if he were taking an opioid, the documentation available shows that he is at low risk for aberrant drug taking behavior. There is no documentation of the reasoning for testing frequency, need for confirmatory testing, or of risk assessment. There is a previous drug screen in the records that demonstrates incorrect collection procedure (no documentation of the patient's current medications), and the results of which were not acted upon. Based on the guidelines cited above and the clinical information provided, a urine drug screen is not medically indicated. A urine drug screen is not medically necessary based on the lack of documentation that the patient is taking an opioid as well as to why a UDS was needed; what was the rationale for the drugs to be tested and the frequency of testing; and because there is concern about incorrect collection procedures and failure to respond to any aberrant results.