

Case Number:	CM14-0111427		
Date Assigned:	08/01/2014	Date of Injury:	10/01/2013
Decision Date:	09/22/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/17/2014

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 54-year old housekeeper reported right foot and ankle pain as well as low back pain after tripping on a cord and falling on 10/1/13. She was initially treated with medications and physical therapy. She did not receive any narcotics. When she did not respond well to these measures, she was referred to a physiatrist, who first examined her on 12/30/13. He prescribed topical diclofenac gel and recommended acupuncture. She was seen for the first time by her current primary treater, an orthopedist, on 1/8/14. He diagnosed myoligamentous thoracic spine sprain, myofascial pain of the rhomboid, and right ankle sprain. He recommended physical therapy and modified duty. There was no documentation that the patient was taking any medications at the time of the visit, or of prescription of any medications. At a 2/5/14 follow-up visit, the primary treater documented that the patient presented with "a bag full of medication including Naproxen, Norflex and Prilosec" which she had obtained from her previous provider. The primary treater documented the same diagnoses as on the first visit, and dispensed Ultram 50 mg. # 90. A urine drug screen was performed at this visit, with the rationale that it was "as per ACOEM/ODG, to evaluate for medication management/pain medication therapy". None of the primary provider's subsequent notes have ever noted or discussed the results of this screen. (It was completely negative.) The patient was seen by the primary provider for a recheck on 5/28/14. The progress note documents that the patient had completed 2 PT sessions and that her pain was improving. She walked normally, and had normal ankle range of motion. There was tenderness of her dorsal right foot. The note does not document that the patient was taking any medications, or that any were prescribed. There is no documentation of performance of, or necessity for a urine drug screen. The primary provider submitted a request dated 6/19/14 for a urine drug screen. It is not clear whether this drug screen had already been performed or was planned. This request was

non-certified in UR on 6/26/14. A request for IMR regarding this decision was generated on 7/16/14.

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. Decision based on Non-MTUS Citation ODG, Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Therapeutic Trial of Opioids page 76; Opioids, Ongoing Management, page 78; Opioids, Steps to Avoid Misuse/Addiction, page 94 Page(s): 76; 78; 94. 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 Official Disability Guidelines 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. There is very little documentation in this case in regards to the requested urine drug screen (UDS). It is not clear when it was performed or was to be performed. The only documented UDS in the available records was performed on 2/5/12. It was entirely negative, and there is no subsequent documented comment about this result by the physician who ordered it. This would suggest that it was not of much importance to him in terms of managing the patient's medications or medical therapy. There is no documentation of any assessment of the patient's risk for aberrant drug behavior, which is supposed to be performed prior to obtaining a UDS. The primary provider appears to be assuming that a UDS in and of itself assesses the patient's risk for aberrant behavior. A urine drug screen collected at a scheduled visit is not random, as is recommended by ODG guidelines. The accompanying request for the 2/5/14 UDS does not document what drugs or herbal preparations the patient is taking, which is also recommended. Testing was performed for multiple drugs outside of the standard drug

classes as recommended by ODG. Tests for barbiturates, buprenorphine, carisoprodol, Fentanyl, meprobamate, oxymorphone, phencyclidine, propoxyphene, tramadol and ethanol were included with no documentation of the indications for these tests. There is no evidence that unexpected (negative) results were confirmed by GCMS. Although it is not clear that the 2/5/12 UDS is the test currently in question, it is likely that any test performed or planned would have been done in the same way, and generated the same concerns as discussed in this paragraph. 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 as to why it is or was needed, what is or was the rationale for the drugs to be tested, and whether or not the requested drug screen is/was random and met/meets guidelines as to how it should be performed.