

Case Number:	CM14-0069863		
Date Assigned:	07/14/2014	Date of Injury:	04/06/2004
Decision Date:	09/10/2014	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	05/15/2014

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 42-year old police officer sustained injuries to his neck and back on 4/6/04. His care for that injury included medication, physical therapy, and epidural injections of the neck. A cervical decompression surgery was performed 11/22/04. He had returned to regular work, but then reported injuries to his neck and back after pushing a stalled work SUV on 5/24/10. Treatment for the more recent injury has included medications, physical therapy and chiropractic treatment. Cervical facet injections were performed on 10/16/13. Multilevel cervical radiofrequency neurotomy was requested and was denied in UR due to lack of a post-neurotomy formal rehabilitation plan. He has been off work for this injury since 7/6/13. Review of the records reveals that multiple urine drug screens have been performed on this patient. Dates include 7/22/13, 8/7/13, 9/4/13, 10/2/13, 11/7/13, 15/5/13, 1/3/14, 1/31/14, and 2/25/14. There is an accompanying note from a visit on all of these dates, many of which contain the statement that there is "no evidence of impairment, abuse, diversion or hoarding" There is no comment on any of the previously performed drug screens in any note in the record, including regarding the 10/2/13 drug screen in which alprazolam was not detected, though the patient was supposedly taking it. A progress note from a physician's assistant in the primary provider's office dated 3/25/14 documents ongoing neck pain, headaches and low back pain. Objective findings include tenderness of the neck and back, with some reduction in range of motion, and a R middle finger sensory deficit. Diagnoses include cervical disc displacement, low back pain/lumbar disc displacement, and headache. A request was made for radiofrequency neurotomy of R C4-C7, with physical therapy to follow the procedure. Prescriptions were given for Norco 5, Xanax, Lexapro 20 and Flexeril. A urine drug screen was performed on the date of this visit, and authorization was subsequently sought, which was denied in UR 4/22/14. A request for IMR was generated 5/12/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for 1 Urine Drug Screening (Date of service: 03/25/2014-03/28/2014):
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates. Decision based on Non-MTUS Citation University of Michigan Health System Guidelines for Clinical Care.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Therapeutic Trial of Opioids; Opioids, Ongoing Management; Opioids, Steps to Avoid Misuse/Addiction 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 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 available clinical records in this case show no documentation that many of the above criteria have been met. There is a recurrent statement in the progress notes that the patient does not exhibit evidence of impairment, abuse, diversion or hoarding, which would suggest that the patient is felt to be low risk, but there is no actual documentation of an assessment of his risk status. A low risk status would not warrant the monthly testing that has been performed since at least 7/22/13. If this testing is being performed for a reason, it is not documented. If there is indeed concern about aberrant drug behavior, testing should be random, which it clearly is not. An aberrant result from 10/2/13 (absence of alprazolam, which the patient was purportedly taking) went unnoticed or uncommented upon in the record, making the reasons for ordering the testing even more unclear. Based on the guidelines referenced and the clinical findings of this case, a urinary drug screen was not medically indicated. The urine drug screen was not medically necessary because evidence-based criteria were not met in regards to documentation

of appropriate evaluation of the patient, of the reasons the test was ordered, and of how the test was performed.