

Case Number:	CM14-0097084		
Date Assigned:	07/28/2014	Date of Injury:	01/29/1998
Decision Date:	10/30/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/25/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Maryland. 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 73 year old female with a work injury dated 1/29/98. The diagnoses include lumbosacral neuritis, lumbar disc displacement, lumbar spinal stenosis without claudication, lumbosacral disc degeneration, and spondylolisthesis; status post L4-5 decompression with ongoing active L4 radiculopathy. Under consideration is a request for a baseline urine toxicology and random and routine urine toxicology every 3 months/90days. There is a primary treating physician report dated 4/21/14. She had a posterior decompression with XLif and interspinous spacer at L4-L5 on 02/19/2013 for symptoms of back and right leg pain. Postoperatively, the symptoms in the right leg improved, but she has been having ongoing numbness across the left thigh sometimes going all the way into the proximate calf area. She continues with physical therapy generally twice per week and she has been on Gabapentin at 600 mg twice per day for some time now. She is still not sure whether or not the Gabapentin has been helpful for her. She still has a lot of numbness in her leg and with prolonged walking she feels some weakness in her leg as if it is going to give out on her. On exam, the low back is generally nontender to palpation. There is some pain over the left lateral hip. There is no pain across the midline. Neurologically, her strength is 5/5 at the hips, knees, and ankles. However, there continues to be positive straight leg raise on the left side with numbness and tingling on the left thigh as well as the calf. The treatment plan includes physical therapy, increased Neurontin. The patient wishes to hold off on surgery. A 5/7/14 document states that the patient will start Cymbalta.

IMR ISSUES, DECISIONS AND RATIONALES

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

Baseline Urine Toxicology: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Also References Opioids Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain, Criteria for Use of Urine Drug Testing

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing, Opioids, steps to avoid misuse/addiction Page(s): 43, 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain(chronic): Urine drug testing (UDT)

Decision rationale: Baseline urine toxicology is not medically necessary per the MTUS Chronic Pain Medical Treatment and ODG Guidelines. The MTUS guidelines state that frequent random urine toxicology screens can be used as a step steps to avoid misuse of opioids, and in particular, for those at high risk of abuse. The MTUS states that urine drug screen is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. The ODG states patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. Patients at "high risk" of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders. The documentation does not reveal evidence of the use of opioids or aberrant behavior. The request for baseline urine toxicology is not medically necessary.

Random and Routine Urine Toxicology every 3 months/90days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Also References Opioids Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain, Criteria for Use of Urine Drug Testing

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing, Opioids, steps to avoid misuse/addiction Page(s): 43, 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain(chronic): Urine drug testing (UDT)

Decision rationale: Random and routine urine toxicology every 3 months/90days is not medically necessary per the MTUS Chronic Pain Medical Treatment and ODG Guidelines. The MTUS guidelines state that frequent random urine toxicology screens can be used as a step steps to avoid misuse of opioids, and in particular, for those at high risk of abuse. The MTUS states that urine drug screen is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. The ODG states patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. Patients at "high risk" of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders. The documentation does not reveal evidence of the use of opioids or aberrant

behavior. The request for random and routine urine toxicology every 3 months/90days is not medically necessary.