

<b>Case Number:</b>	CM14-0199815		
<b>Date Assigned:</b>	12/10/2014	<b>Date of Injury:</b>	06/29/2000
<b>Decision Date:</b>	01/27/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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 Rehab, has a subspecialty in Interventional spine 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:

The patient is a 69-year-old male with a date of injury of 06/29/2000. According to the progress report dated 09/12/2014, the patient continues to have persistent low back and lower extremity pain rated as 10/10 on this date. The patient describes the pain as burning into the low back with intermittent sharp and shooting and stabbing type pain into the legs. It was noted the patient has discontinued Nucynta. His medications do help with his pain level and allow him to increase his activities during the day. Physical examination revealed tenderness and spasm noted in the lumbar paraspinal muscle with stiffness noted on motion. There is decreased range of motion with associated increase in pain. Dysesthesia to light touch in left S1 more than L5 dermatome. Strength is noted as 5/5 in the bilateral lower extremities. The listed diagnoses are: 1. Low back pain. 2. Left wrist pain. 3. Clinically consistent lumbar radiculopathy. 4. Lumbar facet pain. The patient's medication regimen includes Norco 10/325, lactulose, fentanyl 25 mcg, Lunesta 3 mg, Nexium 20 mg, fluoxetine, lidocaine patches, Lyrica, and metaxalone 800 mg. The request is for "urine drug screens up to 4 a year to help monitor and manage medication use and consistency with medications prescribed." The utilization review denied the request on 11/03/2014. Treatment reports from 07/09/2014 through 10/15/2014 were provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Three to four random urine drug screens:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Urine drug screen.

**Decision rationale:** This patient presents with chronic low back pain and lower extremity pain. The current request is for 3 or 4 random urine drug screens. While MTUS Guidelines do not specifically address how frequent UDS should be obtained for various risks of opiate users, ODG Guidelines provide clear recommendation. ODG recommends once yearly urine drug screen following initial screening with the first 6 months for management of chronic opiate use in low-risk patients. The utilization review denied the request stating that previous peer review had made recommendations to wean off opioids and it is not clear if there is further support for UDS. The medical file provides no previous test results. Given that the patient's medication regimen includes multiple opioids, a urine drug screen to monitor for compliance is within guidelines. ODG recommends random screenings on average once yearly for low-risk patients. In this case, the request for three to four random UDS exceeds what is recommended by MTUS and there is no discussion as to why such frequent screenings are being requested. This request is not medically necessary.