MAXIMUS Federal Services

Case Number:	CM14-0206025		
Date Assigned:	12/18/2014	Date of Injury:	03/07/2014
Decision Date:	02/06/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	12/09/2014

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 Internal Medicine and is licensed to practice in New York. 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 43 year old male with a date of injury of 03/07/2014. He had a severe injury of his back, shoulder and left ankle. On 05/23/2014 he had back pain, left shoulder pain and left ankle pain. He also had a left hand laceration on 07/14/2014. He had a L1 vertebral fracture. He had a kyloplasty on 10/25/2014. He had physical therapy and light duty work. On 06/27/2014 he had a left ankle MRI that revealed that there was a compression facture of the navicular bone adjacent to the talus. There was osteoarthrosis of the tibialtalar joint. There was an osteochondral injury of the lateral aspect of the talar dome. He had a compression fracture of the navicluar bone. On 06/27/2014 a MRI of his left shoulder revealed a rotator cuff tear and a degenerative labral tear. On 07/11/2014 he had back pain, left ankle pain and left shoulder pain. On 10/31/2014 he had decreased range of motion of his lumbar spine. He had bilateral decreased sensation at L5 and S1. The left ankle range of motion was decreased. There was left ankle tenderness. On 10/25/2014 and 10/31/2014 urine drug testing was negative.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective review: chromatography quantitative DOS 10/31/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 2014, Back Pain, Urine Drug Testing.

Decision rationale: ODG 2014 Urine Drug Testing: "Recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. The test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. This information includes clinical observation, results of addiction screening, pill counts, and prescription drug monitoring reports. The prescribing clinician should also pay close attention to information provided by family members, other providers and pharmacy personnel. The frequency of urine drug testing may be dictated by state and local laws.Screening Assays: Typically, screening tests are based on immunoassays, which can be either laboratory-based or point-of-collection testing (POC). POC testing is also commonly referred to as "dip-stick" testing. This latter type of testing is performed on-site and usually requires no instrumentation. Substances are reported as present or absent at a predetermined cutoff threshold. Screening assays have the advantages of being more cost effective than confirmatory tests and with POC systems, allow immediate results. These tests cannot identify a specific analyte or distinguish between different drugs of the same class.Limitations of standard immunoassay screens: (1) Differing thresholds can be set (with a positive result only occurring if the cutoff is met with resultant false negatives for drugs below the cutoff); (2) Cross-reactivity between substances chemically related or unrelated to the target drug can produce unreliable results. (3) Semi-synthetic opioids (e.g., oxycodone and oxymorphone and occasionally hydrocodone) and synthetic opioids (fentanyl, meperidine, tramadol, methadone, and buprenorphine) are not detected on many commercially-available opiate immunoassay screens; (4) Benzodiazepine detection may also be unreliable using immunoassay techniques, and a standard screen does not test for alprazolam, Lorazepam or clonazepam; (5) The standard immunoassay screen has a sensitivity of 90% to 95% and specificity of 85% to 90%; Confirmatory Testing: Laboratory-based specific drug identification, which includes gas chromatography/mass spectrometry (GC/MS) or liquid chromatography tandem mass spectrometry (LC/MS/MS). These tests allow for identification and quantification of specific drug substances. They are used to confirm the presence of a given drug, and/or to identify drugs that cannot be isolated by screening tests. The tests also allow for identification of drugs that are not identified in the immunoassay screen. These are generally considered confirmatory tests and have a sensitivity and specificity of around 99%. These tests are particularly important when results of a test are contested.At the onset of treatment: (1) UDT is recommended at the onset of treatment of a new patient who is already receiving a controlled substance or when chronic opioid management is considered. Urine drug testing is not generally recommended in acute treatment settings (i.e. when opioids are required for nociceptive pain). (2) In cases in which the patient asks for a specific drug. This is particularly the case if this drug has high abuse potential; the patient refuses other drug treatment and/or changes in scheduled drugs, or refuses generic drug substitution. (3) If the patient has a positive or "at risk" addiction screen on evaluation. This may also include evidence of a history of comorbid psychiatric disorder such as depression, anxiety, bipolar disorder, and/or personality disorder. See Opioids, screening tests for risk of addiction & misuse. (4) If aberrant behavior or misuse is suspected and/or detected."There was no indication of drug abuse or misuse. Furthermore, it is not appropriate for drug testing on 10/31/2014 when he had back

surgery on 10/25/2014. There was no indication for confirmatory drug testing with chromatography on 10/31/2014 when the initial testing on 10/25/2014 was negative. The patient had severe injuries of his lumbar spine (fracture), left shoulder (rotator cuff and labral tear) and left ankle (compression fracture) and opiate treatment was indicated and there was no documentation of abnormal drug seeking behavior, misuse or aberrant drug behavior to substantiate chromatography urine drug testing.