

<b>Case Number:</b>	CM15-0140693		
<b>Date Assigned:</b>	07/30/2015	<b>Date of Injury:</b>	08/25/2014
<b>Decision Date:</b>	08/27/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/20/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 injured worker is a 79 year old female who sustained an industrial injury on 8-25-14. She had complaints of back and neck pain and a headache. Treatments include medication, physical therapy and injections. Progress report dated 6-12-15 reports complaints of constant neck pain. Since the last epidural injection, she has complaints of severe headaches and ringing in her ears. She has complaints of bilateral shoulder pain, left greater than the right. She also has complaints of right hip pain. She is being prescribed oxycodone from her surgeon for her right wrist injury. Diagnoses include: cervical and thoracic strain, C5-6 cervical disc disease, rule out new thoracic fracture and previous T12 fracture. Plan of care: evaluate for ongoing medication management, qualitative 12 panel urine drug test was administered. Follow up in 6 weeks. Notes indicate that a urine drug screen performed on March 2, 2015 was consistent. A urine drug screen performed on January 7, 2015 was consistent.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 panel urine drug test, retro DOS 6/12/2015: 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 Page(s): 76-79 and 99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter Urine Drug Testing.

**Decision rationale:** Regarding the request for a repeat urine toxicology test (UDS), CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, it appears the patient is taking controlled substance medication. The patient recently underwent 2 urine drug screen within 6 months of the requested date of service. There is no documentation of risk stratification to identify the medical necessity of drug screening at the proposed frequency. Additionally, there is no documentation that the physician is concerned about the patient misusing or abusing any controlled substances. In light of the above issues, the currently requested repeat urine toxicology test is not medically necessary.