

Case Number:	CM15-0145234		
Date Assigned:	08/06/2015	Date of Injury:	04/04/2014
Decision Date:	09/29/2015	UR Denial Date:	07/10/2015
Priority:	Standard	Application Received:	07/27/2015

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: Internal Medicine

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 56-year-old male who sustained an industrial injury on April 4, 2014 resulting in headaches, and severe pain in his neck, low back, both shoulders and both wrists and hands. Diagnoses have included headache, post traumatic head syndrome, displacement of cervical intervertebral disc without myelopathy, lumbago, lumbar radiculitis, right shoulder pain and adhesive tendonitis, left shoulder pain and adhesive bursitis, right and left carpal tunnel syndrome and wrist internal derangement, ankyloses of hand joint, and unspecified derangement of hand joint. Documented treatment has included lumbar transforaminal epidural steroid injection, heat and cold therapy, and medication including Norco 10-325, Neurontin 300 mg, and Soma 350 mg. which physician's progress notes state provides some pain relief along with rest. The injured worker continues to complain of constant, severe pain in the low back and both shoulders, and moderate pain and numbness in both wrists. He also continues having headaches radiating to the neck with numbness and tingling. Pain is interfering with sleep and his ability to perform activities of daily living. The treating physician's plan of care includes a urine toxicology screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine toxicology screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, Pain, - Urine Drug Testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter: Urine drug testing.

Decision rationale: Urine Toxicology screen is 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. Criteria for Use of Urine Drug Testing: Urine drug tests may be subject to specific drug screening statutes and regulations based on state and local laws, and the requesting clinician should be familiar with these. State regulations may address issues such as chain of custody requirements, patient privacy, and how results may be used or shared with employers. The rules and best practices of the U.S. Department of Transportation should be consulted if there is doubt about the legally defensible framework of most jurisdictions. (DOT, 2010) 1. A point-of-contact (POC) immunoassay test is recommended prior to initiating chronic opioid therapy. This is not recommended in acute care situations (i.e. for treatment of nociceptive pain). There should be documentation of an addiction-screening test using a formal screening survey in the records prior to initiating treatment. If the test is appropriate, confirmatory lab testing is not required. See Opioids, screening tests for risk of addiction & misuse. 2. Frequency of urine drug testing should be based on documented evidence of risk stratification including use of a testing instrument. See Opioids, tools for risk stratification & monitoring. An explanation of 'low risk,' 'moderate risk,' and 'high risk' of addiction/aberrant behavior is found under Opioids, tools for risk stratification & monitoring and Opioids, screening tests for risk of addiction & misuse. 3. Patients at 'low risk' of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. 4. 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. This includes patients undergoing prescribed opioid changes without success, patients with a stable addiction disorder, those patients in unstable and/or dysfunction social situations, and for those patients with comorbid psychiatric pathology. 5. 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. 6. If a urine drug test is negative for the prescribed scheduled drug, confirmatory testing is strongly recommended for the questioned drug. If negative on confirmatory testing the prescriber should indicate if there is a valid reason for the observed negative test, or if the negative test suggests misuse or non-compliance. Additional monitoring is recommended including pill counts. Recommendations also include measures such as prescribing fewer pills and/or fewer refills. A discussion of clinic policy and parameters in the patient's opioid agreement is recommended. Weaning or termination

of opioid prescription should be considered in the absence of a valid explanation. See Opioids, dealing with misuse & addiction. 7. If a urine drug test is positive for a non-prescribed scheduled drug or illicit drug, lab confirmation is strongly recommended. In addition, it is recommended to obtain prescription drug monitoring reports. If there is evidence of problems with cross-state border drug soliciting in your area, reports from surrounding states should be obtained if possible. Other options include contacting pharmacies and different providers (depending on the situation). Reiteration of an opioid agreement should occur. Weaning or termination of opioid prescription should be considered in the absence of a valid explanation. In this case, there is no indication that the patient is misusing his medication and no evidence of medication noncompliance. This patient is considered low risk. Therefore, based on ODG guidelines and the information in this case, the request for urine toxicology screen is not indicated and not medically necessary.