

<b>Case Number:</b>	CM15-0182407		
<b>Date Assigned:</b>	09/30/2015	<b>Date of Injury:</b>	04/12/2012
<b>Decision Date:</b>	11/12/2015	<b>UR Denial Date:</b>	08/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2015

### 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 female who sustained an industrial injury on 4-12-12. A review of the medical records indicates she is undergoing treatment for degeneration of cervical intervertebral disc, brachial neuritis or radiculitis, cervicgia, spinal stenosis in cervical region, and spasm of muscle. Medical records (4-15-15 to 7-22-15) indicate complaints of neck pain radiating into the right arm. She rates the pain "3 out of 10" (7-15-15). The physical exam (7-15-15) reveals decreased range of motion of cervical flexion, extension, and lateral rotation "to 80% of normal". The treating provider indicates range of motion is "limited by stiffness, but non-tender". Spurling's test is positive bilaterally. Motor function is "5 out of 5" in bilateral upper extremities. Sensory perception is "intact" in bilateral upper extremities. However, the treating provider states "she continues to have intermittent paresthesias in right shoulder and hand in the distribution of C6 and C7". She underwent a urine drug screen on 4-15-15 (per report in progress record) and 7-22-15. The 7-22-15 report indicates "negative" results for all tested medications. Her current medications (7-15-15) include Lexapro 5mg once daily. The utilization review (8-17-15) indicates a request for authorization for urine toxicology screen with dates of service of 4-15-15 and 7-22-15. Both requests were denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Urine toxicology screen/labs (Retro DOS: 04/15/2015 and 07/22/2015): Upheld**

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Opioids, 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): Urine Drug Testing.

**Decision rationale:** Based on ODG guidelines, urine drug testing 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. State and local laws may dictate the frequency of urine drug testing. Indications for UDT: 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. See Opioids, indicators for addiction & misuse. Ongoing monitoring: (1) If a patient has evidence of a high risk of addiction (including evidence of a comorbid psychiatric disorder (such as depression, anxiety, attention-deficit disorder, obsessive-compulsive disorder, bipolar disorder, and/or schizophrenia), has a history of aberrant behavior, personal or family history of substance dependence (addiction), or a personal history of sexual or physical trauma, ongoing urine drug testing is indicated as an adjunct to monitoring along with clinical exams and pill counts. See Opioids, tools for risk stratification & monitoring. (2) If dose increases are not decreasing pain and increasing function, consideration of UDT should be made to aid in evaluating medication compliance and adherence. In this case, there is no evidence of aberrancy with treatment regimen, nor concern for medication misuse. Also, based on the patients medication list, she is only taking Lexapro. She is not taking any narcotics/opiates, which may require periodic drug testing. There is no clear indication for doing urine toxicology screens in this case. Therefore, based on the evidence in this case and the ODG guidelines, the request for urine toxicology screen/labs (Retro 4/15/2015 and 7/22/2015) is not medically necessary.