

Case Number:	CM15-0209007		
Date Assigned:	10/28/2015	Date of Injury:	12/05/2007
Decision Date:	12/09/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	10/23/2015

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, Indiana, New York
 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:

This injured worker is a 59 year old male who reported an industrial injury on 12-5-2007. His diagnoses, and or impressions, were noted to include: lumbosacral spondylosis; lumbar-lumbosacral disc degeneration; and lumbosacral neuritis. No current imaging studies were noted; however, lumbar x-rays were done on 7-9-2014; with MRI of the lumbar spine on 4-8- 2008, 11-30-2010 & 5-16-2014; and MRI of the cervical spine on 8-11-2008, 4-19-2013 & 5-12-2014. His treatments were noted to include: physical therapy; ice-heat therapy; medication management; and a return to part-time work. The progress notes of 9-15-2015 reported decreased pain in his lumbar spine with unchanged pain in his right buttocks and bilateral legs; that he worked part-time; that Ibuprofen had provided 50% benefit allowing him to perform unassisted activities of daily living, until the more intense pain returned; and difficulty with sleep. Medication refills were noted to have been needed at the 8-27-2015 visit, but noted not needed at this visit. The objective findings were noted to include: no acute distress; tenderness over the bilateral lumbar facets; bilateral thoracolumbar spasms; positive left straight leg raise at 60 degrees; painful-decreased range-of-motion; decreases bilateral Achilles reflexes; decreased right knee extension & dorsiflexion; and axial low back pain that moved laterally and down his legs which had, in the past, responded to epidural steroids. The physician's requests for treatment were noted to include monitoring with a urine drug screen to document, evaluate and monitor controlled substances and drug compliance in them management of chronic pain. No Request for Authorization for an outpatient urine drug screen was noted in them medical records provided. The Utilization Review of 9-24-2015 non-certified the request for an out-patient urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing, Opioids, steps to avoid misuse/addiction.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Urine drug screen.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, urine drug screen is not medically necessary. 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. This test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. The frequency of urine drug testing is determined by whether the injured worker is a low risk, intermediate or high risk for drug misuse or abuse. Patients at low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. For patients at low risk of addiction/aberrant drug-related behavior, there is no reason to perform confirmatory testing unless the test inappropriate or there are unexpected results. If required, confirmatory testing should be the questioned drugs only. In this case, the injured worker's working diagnoses are lumbosacral spondylosis; lumbar / lumbosacral disc degeneration; and lumbosacral neuritis NOS. Date of injury is December 5, 2007. Request for authorization is September 15, 2015. According to a September 15, 2015 progress note, the injured worker received a bilateral L5 on August 17, 2015. It is unclear whether this represents a medial branch blocks or an epidural steroid injection. Subjective complaints include low back pain that radiates to the right buttocks 7/10. Medications do not include any opiates or controlled substances. Medications are Aciphex, ibuprofen, Lidoderm, aspirin, Vytarin and over-the-counter medications. Objectively, there is tenderness to palpation right lumbar facet, left lumbar facets, right and left thoraco-lumbar spasm. The treatment plan indicates a urine drug screen was ordered to document, evaluate and monitor controlled substances and drug compliance in the management of chronic pain and to rule out from diversion, presence of illicit drugs or other controlled substances not prescribed by the treating providers. There is no documentation of aberrant drug-related behavior, drug misuse or abuse. There is a consistent urine drug toxicology screen dated March 25, 2015. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation showing aberrant drug-related behavior, drug misuse or abuse, no documentation showing high risk drug-related behavior, a consistent urine drug toxicology screen dated March 25, 2015 and no clinical indication or rationale for repeating the urine drug toxicology screen, urine drug screen is not medically necessary.