

Case Number:	CM15-0210287		
Date Assigned:	10/29/2015	Date of Injury:	01/15/1999
Decision Date:	12/15/2015	UR Denial Date:	10/14/2015
Priority:	Standard	Application Received:	10/26/2015

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:

This is a 67 year old female who sustained a work-related injury on 1-15-19. Medical record documentation on 7-28-15 revealed the injured worker was being treated for status post lumbar fusion, status post removal of hardware, grad I spondylolisthesis L2-3, chronic pain syndrome, status post spinal cord stimulator implantation, and right distal radius buckle fracture. She reported ongoing pain in the upper back, mid back and down the bilateral lower extremities. She reported tenderness at the top of the back, which would ache and affect her posture. She rated her pain a 5 on a 10-point scale and noted her pain level reduced to a 3 on a 10-point scale with medications and spinal cord stimulator. Her medication regimen included Ibuprofen 800 mg, Lidoderm 6% patch, Percocet 5-325 mg, Norco 5-325 mg, and Topamax 50 mg. Objective findings included lumbar range of motion of forward flexion to 65 degrees and extension to 5 degrees. She was able to stand up straight and had less antalgic movements. Documentation on 5-19-15 indicated the injured worker had no aberrant drug behaviors and used her medications as prescribed. A request for urine drug screen was received on 7-30-15. On 10-14-15, the Utilization Review physician determined urine drug screen on 8-5-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine drug screen (completed 8/5/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, steps to avoid misuse/addiction. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 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 (UDT).

Decision rationale: Based on ODG guidelines, the Criteria for Use of Urine Drug Testing is as follows: 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 [REDACTED] [REDACTED] should be consulted if there is doubt about the legally defensible framework of most jurisdictions. ([REDACTED], 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. 8. Urine drug testing positive for illicit drugs places a patient in a "high risk" category. 9. If unexpected results are found, documentation of the ensuing conversation, including patient's explanation should be made. 10. Documentation should make evident the reason(s) that confirmatory tests are required. This includes information about the actual classes of drugs requested for testing. 11. There should be specific documentation for the necessity of confirmatory testing of drug class panels such as antidepressants, benzodiazepines, acetaminophen and salicylates. Routine confirmatory screening of these classes of drugs is generally reserved for emergency department testing for overdose patients. 12. If UDT is a standard protocol for in-office use, it is recommended that the clinician establish a routine immunoassay panel. Standard drug classes recommended include cocaine metabolite, amphetamines, opiates (morphine, codeine and 6-MAM), opioids (oxycodone and methadone), marijuana (delta-9-THC), barbiturates and benzodiazepines. In settings where there is frequent use of other drugs, particularly semi-synthetic or synthetic opioids, these should be added. Drugs of abuse in your community should also be included. 13. Prescribers may wish to request limit of detection testing (i.e. decreased thresholds) to increase the likelihood of detecting prescribed drugs. This is particularly important for patients on intrathecal drugs as well as for patients on fentanyl patches. In this case, the patient appears to be low risk for aberrant behavior and addiction. There has been no documentation of behavior contrary to the above. Also, there is no definitive documentation as far as dates and results of previous urine drug testing. Therefore, based on the evidence and the ODG guidelines, the request for urine drug screen (completed 8/5/15) is not medically necessary.