MAXIMUS Federal Services

| Case Number: | CM15-0051063 | | |
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| Date Assigned: | 03/24/2015 | Date of Injury: | 10/15/2012 |
| Decision Date: | 05/01/2015 | UR Denial Date: | 02/20/2015 |
| Priority: | Standard | Application Received: | 03/17/2015 |

## 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:

The injured worker is a 27-year-old male, with a reported date of injury of 10/15/2012. The diagnoses include low back pain, chronic pain, degeneration of the lumbar intervertebral disc, and lumbosacral spondylosis without myelopathy. Treatments to date have included oral medications, physical therapy, transcutaneous electrical nerve stimulation (TENS) unit, bilateral lumbar intra-articular facet corticosteroid injections, bilateral lumbar medial branch nerve rhizotomies, and stretching. The medical report dated 02/10/2015 indicates that the injured worker complained of low back pain. The pain was also located in the gluteal area and knees. He rated his pain 6 out of 10 without medications and 4 out of 10 with medications. A physical examination of the low back showed normal muscle tone, tenderness of the paraspinal facet, gluteals, spinous, and sacroiliac joint, right buttock pain, negative straight leg raise, and pain over the facet joints. The medications were renewed, and the plan was to continue to periodically monitor for adherence with a urine drug screen, CURES report, and routine labs. The treating physician requested a urine drug screen (date of service 02/10/2015).

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective urine drug screen with date of service 2/10/15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-77-78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-pain chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Toxicology Screen Page(s): 43. 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, retrospective urine drug testing data service February 10, 2015 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 sacroiliitis chronic; chronic pain due to trauma; facet arthropathy; degenerative disease lumbar; spondylosis lumbar without myelopathy. The documentation shows a urine drug screen was ordered on December 17, 2014. The results were consistent. The treating physician ordered a second urine drug toxicology screen on February 10, 2015. There is no clinical indication or rationale for a second urine drug toxicology screen. There was no risk assessment of the medical record indicating the injured worker was at intermediate or high risk for drug misuse or abuse. In a low risk worker with a low risk of addiction/aberrant behavior, urine drug testing should be conducted within six months of initiation of therapy and on a yearly basis thereafter. The treating physician requested a second random urine drug toxicology screen two months after the first one in December 2014 that was consistent. Consequently, absent compelling clinical documentation with a clinical indication/rationale for a second urine drug screen 60 days after the first, retrospective urine drug testing date of service February 10, 2015 is not medically necessary.