

<b>Case Number:</b>	CM15-0054829		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	08/26/1988
<b>Decision Date:</b>	05/14/2015	<b>UR Denial Date:</b>	03/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 63-year-old male who reported an injury on 08/26/1988. The mechanism of injury was not specifically stated. The current diagnoses include sacroiliitis, lumbar radiculopathy, chronic low back pain, status post lumbar laminectomy in 1970, status post cervical fusion, status post lumbar fusion, medication induced gastritis, status post removal of bone stimulator on 09/06/2012, history of substance abuse, and status post ACDF on 04/18/2013. The injured worker presented on 01/20/2015, for a follow-up evaluation regarding low back and left lower extremity pain. The injured worker noted ongoing pain in the low back, increased in severity by 40% over the past month. Previous conservative treatment includes bilateral SI joint injections in 09/2014 and 10/2014. The injured worker was utilizing Percocet 10/325 mg, Topamax 50 mg, Robaxin 750 mg, and Neurontin 1200 mg. Upon examination, there was an antalgic gait, tenderness over the lumbar paraspinal muscles, severe tenderness over the bilateral PSIS, pain in the bilateral groin area with internal and external rotation of the bilateral hips, 4+/5 weakness, positive Faber test on the right, and positive Gaenslen's maneuver on the right. A urine drug screen performed on 04/09/2014, was reportedly consistent with the prescribed regimen. Laboratory studies obtained on 10/14/2013, also revealed a creatinine of 1.131, and an LAK PHOS of 157. Recommendations at that time included continuing the current medication regimen, a right SI joint injection, a pain management consultation, and a MED panel. A Request for Authorization form was then submitted on 01/20/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Urine Drug Screen for 10 drug classes:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 77, and 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

**Decision rationale:** California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. Patients at low risk of addiction or aberrant behaviors should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. As per the clinical notes submitted, there is no mention of non-compliance or misuse of medication. There is no indication that this injured worker falls under a high-risk category that would require frequent monitoring. Therefore, the current request is not medically necessary.

**Creatinine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**PH:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Spectrophotometry, Analyte:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.