

Case Number:	CM15-0076380		
Date Assigned:	04/28/2015	Date of Injury:	08/24/2011
Decision Date:	09/29/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	04/21/2015

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 51 year old female who sustained a work related injury August 24, 2011. Past history included bilateral shoulder surgery with residuals; status post lumbar discectomy. A positive report of an MRI of the lumbar spine, dated February 21, 2015, is present in the medical record. A positive report of an MRI of the cervical spine, dated March 31, 2015, is present in the medical record. According to a primary treating physician progress report, dated February 16, 2015, the injured worker presented with complaints of left and right lumbar pain, right and left anterior shoulder pain, and right anterior knee pain all associated with numbness and tingling. She rated her pain 7 out of 10. Diagnoses are displacement of lumbar intervertebral disc without myelopathy; left shoulder adhesive capsulitis; right shoulder internal derangement, unspecified; internal derangement left knee, unspecified. Treatment plan included Norco for severe pain, topical medication; Flurbiprofen and Tramadol to be applied to affected areas to reduce pain, a home interferential stimulator unit, and at issue, a request for authorization for a urine drug test.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine drug test: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

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) Chapter: 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. The frequency of urine drug testing may be dictated by state and local laws. Criteria for Use of Urine Drug Testing. 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 U.S. Department of Transportation should be consulted if there is doubt about the legally defensible framework of most jurisdictions. (DOT, 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. In this case, there is no documentation of concern for aberrancy from drug treatment regimen and no mention of possible medication misuse. This patient appears to be low risk for medication misuse and a urine drug screen does not appear to be indicated in this situation. Therefore, based on ODG guidelines and the information in this case, the request for a urine drug test is not medically necessary.