

Case Number:	CM14-0127334		
Date Assigned:	09/23/2014	Date of Injury:	06/14/2007
Decision Date:	10/22/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	08/12/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 56-year-old female with a 6/14/07 date of injury. The mechanism of injury occurred while lifting a box of files, pulling her right upper leg muscle. The patient was seen by a pain medicine specialist on 6/25/14, when the patient complained of a burning and electrical pain in the right lower extremity rated as 7/10 with medications. Without medications, the pain was noted to be 9-10/10. The patient stated that her ability to perform activities of daily living had increased since her last visit. Exam findings revealed moderate tenderness in the midline L-spine and hypesthesia over the right lower extremity. The patient's diagnoses included complete sciatic nerve palsy of the right lower extremity, L-spine musculoligamentous strain syndrome, left hip strain, and history of avascular necrosis status post right total hip replacement. The patient's medications included Gabapentin 600mg PO TID (by mouth 3x a day), acetaminophen PRN (as needed), aspirin, and omeprazole. It was noted that the patient had been compliant with her prescription guidelines and attempted to reduce medications when able to. The patient signed a pain medication agreement and demonstrated no drug seeking behaviors. The progress report stated that a random urine drug screen (UDS) was requested for the purpose of monitoring and ensuring compliance with use of Schedule II and III prescription medications. The documentation noted a UDS dated 6/10/2013 in which the results were consistent with the patient's prescribed medications of oxazepam and temazepam at that time. Treatment to date: medications, right total hip replacement, neurolysis of the right sciatic nerve and decompression of the superficial deep peroneal nerves, home exercise program. An adverse determination was received on 7/14/14 due to the documentation noting the patient's compliance with the medication regimen and no evidence of drug-seeking behaviors. There was also no report of illicit drug use or abuse of prescription medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Random urine drug screen quarterly QTY: 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 77.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 2009 (Drug Testing page 43 Urine testing in ongoing opiate management page 78) Page(s).

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that a urine analysis is recommended as an option to assess for the use or the presence of illegal drugs, to assess for abuse, to assess before a therapeutic trial of opioids, addiction, or poor pain control in patients under on-going opioid treatment. This patient complained of a chronic burning and electrical pain in the right lower extremity during her clinic visit on 6/25/14. It was noted that the pain improved with gabapentin and acetaminophen PRN. The treatment plan included the continuation of gabapentin, and no new medications were prescribed at that visit. The progress note stated that the patient had been compliant with her prescription guidelines and attempted to reduce medications when able to. The patient had signed a pain medication agreement and demonstrated no drug seeking behaviors. The progress note stated that a random UDS was requested for the purpose of monitoring and ensuring compliance with use of Schedule II and III prescription medications. Given the lack of documentation indicating any aberrant behavior exhibited by this patient, diversion or non-compliance with the medication regimen, it was unclear what the rationale was for a random quarterly UDS. Furthermore, this patient was not on any Schedule II or III prescription medications according to the progress note. Therefore, the request for a random urine drug screen quarterly #4 was not medically necessary.