

<b>Case Number:</b>	CM14-0183829		
<b>Date Assigned:</b>	11/10/2014	<b>Date of Injury:</b>	10/24/2008
<b>Decision Date:</b>	12/15/2014	<b>UR Denial Date:</b>	10/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Massachusetts. 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:

According to the documents available for review, the patient is a 65 year old male. The date of injury is 10/24/2008. The patient sustained an injury to the cervical spine. The specific mechanism of injury was not fully elaborated on in the notes available for review. The patient currently complains of pain in the neck worse with movement. The current diagnosis is cervical strain. A request for urine drug screen was denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 Urine Drug Screen:** Upheld

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

**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), Drug Testing

**Decision rationale:** Urine screens are 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.

**Indications for UDT:** At the onset of treatment: (1) UDT is recommended at the onset of treatment of a new patient who is already receiving a controlled substance or when chronic opioid management is considered. Urine drug testing is not generally recommended in acute treatment settings (i.e. when opioids are required for nociceptive pain). (2) In cases in which the patient asks for a specific drug. This is particularly the case if this drug has high abuse potential; the patient refuses other drug treatment and/or changes in scheduled drugs, or refuses generic drug substitution. (3) If the patient has a positive or "at risk" addiction screen on evaluation. This may also include evidence of a history of comorbid psychiatric disorder such as depression, anxiety, bipolar disorder, and/or personality disorder. See Opioids, screening tests for risk of addiction & misuse. (4) If aberrant behavior or misuse is suspected and/or detected. See Opioids, indicators for addiction & misuse.

**Ongoing monitoring:** (1) If a patient has evidence of a "high risk" of addiction (including evidence of a comorbid psychiatric disorder (such as depression, anxiety, attention-deficit disorder, obsessive-compulsive disorder, bipolar disorder, and/or schizophrenia), has a history of aberrant behavior, personal or family history of substance dependence (addiction), or a personal history of sexual or physical trauma, ongoing urine drug testing is indicated as an adjunct to monitoring along with clinical exams and pill counts. See Opioids, tools for risk stratification & monitoring. (2) If dose increases are not decreasing pain and increasing function, consideration of UDT should be made to aid in evaluating medication compliance and adherence.

**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.

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.14. A detailed list of all drugs the patient is taking including over-the-counter drugs and herbal preparations must be included in the request accompanying the test. When using confirmatory testing, this allows for the lab to provide accurate assessment. The progress note should also indicate a complete list of drugs with the last time of use of specific drugs evaluated for.15. Random collection is recommended.16. If tampering is suspected, check urine temperature, pH and creatinine concentration. It is also recommended to ask for an immediate second sample or witness the collection.17. Results of testing and interpretation should be documented in the patient's chart to document compliance or deviation. This is especially true if results can lead to alteration or termination of care. Termination of care should never be based solely on the lack of detection of a prescribed medication on a screening assay. Such findings should be confirmed by another method, to diminish the likelihood of a false negative result leading to inappropriate termination of care.18. It is recommended that a toxicologist be available to discuss any questions that may occur surrounding tests.19. Quantitative urine drug testing is not recommended for verifying compliance without evidence of necessity. This is due in part to pharmacokinetic and pharmacodynamic issues including variability in volumes of

distribution (muscle density) and interindividual and intraindividual variability in drug metabolism. Any request for quantitative testing requires documentation that qualifies necessity. According to the documents available for review, the patient meets none of the aforementioned MTUS criteria for the use of urine drug testing. Therefore at this time the requirements for treatment have not been met, and medical necessity has not been established.