

<b>Case Number:</b>	CM14-0082860		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	12/14/2009
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	05/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/04/2014

### 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 Family 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 54-year old male reported a R knee injury with a date of 12/14/09. The available records do not contain any information about the mechanism of injury, and little about his subsequent treatment. The UR report of 5/15/04 states that the patient received two ACL reconstructions, and was made permanent and stationary with the respect to the R knee by an orthopedic QME on 9/29/11. The patient presented to a chiropractor's office on 3/14/12 with complaints of bilateral knee pain, right hip pain, right ankle pain and hypertension. He continued to be followed by the chiropractor for all of these presenting complaints. The records do contain the following report, which I have summarized. On 3/12/14, the patient was evaluated by an MD. The past medical history was documented as "none". Current medications were also documented as none. His complaints were documented as R knee pain and buckling, and inability to walk long distances. Exam findings were documented as s/p R knee surgery, wearing brace, antalgic gait, and pain radiates to R foot. Medications were apparently dispensed including Condrolite 500/200/150 #90, Cyclobenzaprine 7.5.mg #60, Naproxen 550 mg #60, and Omeprazole 20 mg #60. Gabapentin/Flurbiprofen topical cream was dispensed, with additional cream to be mailed to the patient's home. A urine drug screen was performed. An attached form states that the urinalysis performed on 3/12/14 was performed to obtain baseline results that can help in more accurately predicting future compliance to a prescribed medication treatment program in addition to determining the presence of illicit drugs in the patient's system. According to the UR note, the patient was re-evaluated by a physician's assistant on 4/9/14. A urine drug screen was performed with no rationale documented. (This progress note is not in the records available.) A request for authorization for the urine drug screen was received in UR on 4/23/14 and denied on 5/15/14. A request for IMR of the decision was generated on 5/20/14.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**URINE DRUG SCREEN:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Therapeutic Trial of Opioids, Opioids, Ongoing Management, Opioids, Steps to Avoid Misuse/Addiction Page(s): 76,78,94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Section, Urine Drug Testing, criteria for use.

**Decision rationale:** Per the MTUS guidelines cited above, an assessment of the likelihood for substance abuse should be made before a therapeutic trial of opioid use is begun. The section on ongoing management of opioid use recommends that regular assessment for aberrant drug taking behavior should be performed. Drug screens should be used in patients with issues of abuse, addiction or poor pain control. The section on steps to avoid misuse/addiction recommends frequent random urine toxicology screens. Per the ODG reference cited, clinicians should be clear on the indication for using a UDS prior to ordering one. Testing frequency should be determined by assessing the patient's risk for misuse, with low-risk patients to receive random testing no more than twice per year. Documentation of the reasoning for testing frequency, need for confirmatory testing, and of risk assessment is particularly important in stable patients with no evidence of risk factors or previous aberrant drug behavior. Standard drug classes should be included in the testing, including cocaine, amphetamines, opiates, oxycodone, methadone, marijuana, and benzodiazepines. Others may be tested as indicated. A complete list of all drugs the patient is taking, including OTC and herbal preparations must be included in the request accompanying the test, as well as documentation of the last time of use of specific drugs evaluated for. Random collection is preferred. Unexpected results (illicit drugs, scheduled drugs that were not prescribed, or negative results for a prescribed drug) should be verified with GCMS. The clinical findings in this case show that two urine drug screens have been ordered within about 5 weeks on this patient. The first screen had a documented rationale that it was performed to obtain baseline results that can help in more accurately predicting future compliance to a prescribed medication treatment program, in addition to determining the presence of illicit drugs in the patient's system. A drug screen should not be used as a tool to determine that patient's risk for aberrant drug behavior or non-compliance. This assessment should be made first, and the drug screen performed if the patient is at risk. It is difficult to understand why a drug screen would have been performed on a patient who was taking no medications at all, and whose prescriptions did not include any opioids. It is particularly difficult to understand why a drug screen was repeated within five weeks. This patient appears to be at low risk for abuse potential, and guidelines would support testing him at most twice per year. In addition, there is no documentation of how the UDS was performed, what drugs were tested for, and whether or not GCMS was available for unexpected results. Taking into account the evidence-based references cited above and the clinical findings in this case, a urine drug screen was not clinically indicated. A urine drug screen was not medically necessary due to lack of documentation of the patient's risk for aberrant drug behavior, as well as lack of documentation

of the reason for testing frequency, of the drugs being tested, and of the need for confirmatory testing.