| | | | |
|---|---|---|---|
| **Case Number:** | CM14-0219063 | | |
| **Date Assigned:** | 01/09/2015 | **Date of Injury:** | 07/31/2003 |
| **Decision Date:** | 03/10/2015 | **UR Denial Date:** | 12/11/2014 |
| **Priority:** | Standard | **Application Received:** | 12/31/2014 |

## 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. 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, Indiana, New York
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 (IW) is a 57 year old male, who sustained an industrial injury on July 31, 2003. He has reported low back pain with associated tingling and numbness and was diagnosed with post lumbar laminectomy syndrome, lumbosacral radiculitis and vomiting with nausea. Treatment to date has included surgical consultation, surgical intervention, diagnostic studies, laboratory studies, radiographic imaging, intrathecal pain pump placement in 2007 and oral pain medications.Currently, the IW complains of chronic low back pain.The IW reported continued back pain after the above noted treatments starting in 2003 at the time of the injury. Documentation revealed multiple follow up appointments for pain pump and medication evaluations. There was noted improvement in the ability to perform activities of daily living and in pain intermittently. It was noted the IW was due for a pain pump exchange however on pre-operative evaluation on September 8, 2014, laboratory studies revealed MRSA colonization. The procedure was postponed for at least one week for treatment. Evaluation on September 15, 2014 revealed a negative MRSA swab. On October 2, 2014, the intrathecal pain pump was exchanged with no noted complications. On November 5, 2014, the surgical wounds were noted as healing with no signs of infection. The IW still complained of chronic back pain. On January 2, 2015, the chief complaint was back pain however on evaluation of the effectiveness of the pain pump, no rescue pain was of concern. A request for serum toxicology tests was made. There were no substantial changes documented and no noted suspicion of medication intoxication.On December 11, 2014, Utilization Review non-certified two serum toxicology tests, noting the MTUS

Chronic Pain Medical Treatment guidelines.On December 30, 2014, the injured worker submitted an application for IMR for review of a request for two serum toxicology screenings.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Serum Toxicology x2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug screen Page(s): 43. Decision based on Non-MTUS Citation Pain section, Urine drug screen

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, serum toxicology # 2 is not medically necessary. 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. This test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. The frequency of urine drug testing is determined by whether the injured worker is a low risk, intermediate or high risk for drug misuse or abuse. Patients at low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at moderate risk for addiction/aberrant behavior are recommended for point of contact screening to three times a year with confirmatory testing for inappropriate or unexplained results. Patients at high risk of adverse outcomes may require testing as often as once per month. In this case, the injured workers working diagnoses are post lumbar laminectomy syndrome; lumbosacral radiculitis semicolons and vomiting with nausea. The injured worker had a lumbar surgical intervention in 2003, diagnostic studies, laboratory studies, radiographic imaging, intrathecal pain pump placement 2007, replacement in 2014, an oral pain medications. Subjectively, the injured worker has ongoing lumbosacral pain with bilateral lower extremity radiculopathy. The injured worker's medications are Lunesta, Zofran, Pristiq, to vanity, intrathecal fentanyl, hydromorphone and Droperidol. The treating physician does not provide a clinical rationale of indication for serum toxicology screenings. Urine drug toxicology screens are readily available and are indicated as a tool to monitor compliance with prescribed substances. The documentation in the medical record indicates the injured worker was a medium-risk for drug misuse and abuse on September 3, 2014 and then reclassified as a high-risk category on October 29, 2014. Urine drug toxicology screens, as noted above, are readily as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances and uncovered the version of prescribed substances. Consequently, absent a clinical rationale/indication for serum toxicology screens when urine drug toxicology screens are readily available, serum toxicology #2 is not medically necessary.