

<b>Case Number:</b>	CM15-0175361		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	04/21/2012
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	08/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2015

### 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: Emergency 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:

This is a 50 year old male with a date of injury of April 21, 2012. A review of the medical records indicates that the injured worker is undergoing treatment for left shoulder pain. Medical records dated July 16, 2015 indicate that the injured worker complains of constant pain in the left shoulder rated at a level of 5 out of 10 that radiates to the rhomboid. A progress note dated August 4, 2015 notes subjective complaints of left shoulder pain rated at a level of 5 out of 10. Per the treating physician (July 16, 2015), the employee was able to return to work with no restrictions. The physical exam dated July 16, 2015 reveals tenderness at the super scapula and rhomboid. The progress note dated August 4, 2015 documented a physical examination that showed left shoulder tenderness, decreased range of motion, spasm, and positive impingement sign. Treatment has included cortisone injection of the left shoulder, medications (Norco since at least March of 2015; Flector patches since at least May of 2015; Pennsaid since at least June of 2015 Ibuprofen since at least July of 2015), and an unknown number of physical therapy sessions. The original utilization review (August 18, 2015) non-certified a request for Cyclobenzaprine 7.5mg #60, Topical Compound Cream: Flurbiprofen 10%, Capsaicin 0.25%, Camphor 2% 120gm, x-ray of the right shoulder, magnetic resonance imaging of the right shoulder, Ketoprofen 10%, Cyclobenzaprine 3%, Lidocaine 5% 120gm, Tramadol HCL 50mg #50, magnetic resonance imaging of the left shoulder, Autonomous nervous study, eight sessions of chiropractic therapy, four sessions of acupuncture, Pantoprazole 20mg #60, Sudo scan, functional capacity evaluation, interferential unit, and urinalysis for toxicology.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 7.5mg 1 tab po bid #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate documentation of a recent acute exacerbation and poor effectiveness for chronic long-term use, the request is not medically necessary.

**Topical Compound Cream: Flurbiprofen 10%, Capsaicin 0.25%, Camphor 2% 120gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** The request is for the use of a topical NSAID for pain relief. There are specific criteria require for use based on the guidelines. The MTUS states the following: The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, as indicated above, the patient would not qualify for the use of this medication based on the treatment duration. As such, the request is not medically necessary.

**X-Ray of the Right Shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder complaints/diagnostic criteria.

**Decision rationale:** The request is for shoulder x-rays. The ACOEM guidelines state that radiographic films are indicated in cases of suspected fracture or dislocation, shoulder instability, or AC separation. When non-specific or overuse shoulder pain exists, no x-rays are advised. In this case, x-rays are not indicated. This is secondary to inadequate documentation of physical exam findings such as suspected fracture or dislocation after acute trauma. As such, the request is not medically necessary.

**MRI of the Right Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic)/MRI.

**Decision rationale:** The request is for an MRI of the shoulder. The Official Disability Guidelines state the following regarding the qualifying indications: Indications for imaging Magnetic resonance imaging (MRI): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs, Subacute shoulder pain, suspect instability/labral tear, Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008) In this case, this study is not indicated. This is secondary to inadequate documentation of qualifying indications as listed above. As such, the request is not medically necessary.

**Ketoprofen 10%, Cyclobenzaprine 3%, Lidocaine 5% 120gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the use of the topical muscle relaxant is not indicated for use for the patient's condition. The MTUS states the following regarding muscle relaxants used topically: "Baclofen: Not recommended. There is currently one Phase III study of Baclofen-Amitriptyline-Ketamine gel in cancer patients for treatment of chemotherapy-induced peripheral neuropathy. There is no peer-reviewed literature to support the use of topical baclofen. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." As indicated above, due to inadequate clinical evidence of efficacy, the request is not medically necessary.

**Tramadol HCL 50mg 1 tab po bid #50:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** Tramadol is a pain medication in the category of a centrally acting analgesic. They exhibit opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Centrally acting drugs are reported to be effective in managing neuropathic type pain although it is not recommended as first line therapy. The side effect profile is similar to opioids. For chronic back pain, it appears to be efficacious for short term pain relief, but long term (>16 weeks) results are limited. It also did not appear to improve function. The use of tramadol for osteoarthritis is indicated for short term use only (< 3 months) with poor long-term benefit. In this case, the patient does not meet the qualifying criteria. This is secondary to the duration of use, with this medication being indicated on a short-term basis only. As such, the request is not medically necessary.

**MRI Left Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic)/MRI.

**Decision rationale:** The request is for an MRI of the shoulder. The Official Disability Guidelines state the following regarding the qualifying indications: Indications for imaging Magnetic resonance imaging (MRI): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs, Subacute shoulder pain, suspect instability/labral tear, Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008) In this case, this study is not indicated. This is secondary to inadequate documentation of qualifying indications as listed above. As such, the request is not medically necessary.

**Autonomic Nervous Study:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

**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)/Autonomic nervous system function testing/CRPS, diagnostic tests.

**Decision rationale:** The request is for autonomic testing. The MTUS guidelines are silent regarding this issue. The official disability guidelines state the following regarding this topic: "Specific procedures are not generally recommended, except as indicated below. A gold standard for diagnosis of CRPS has not been established and no test has been proven to diagnose this condition. Assessment of clinical findings is currently suggested as the most useful method of establishing the diagnosis. The following procedures have been suggested for use as additional tools for diagnosis, with use based on the patient's medical presentation." The following recommendations are made based on consensus guidelines: Recommendations (based

on consensus guidelines) for an adequate CRPS evaluation: (1) There should be evidence that the Budapest (Hardin) criteria have been evaluated for and fulfilled. (2) There should be evidence that all other diagnoses have been ruled out. A diagnosis of CRPS should not be accepted without a documented and complete differential diagnostic process completed as a part of the record. (3) If a sympathetic block is utilized for diagnosis, there should be evidence that this block fulfills criteria for success including that skin temperature after the block shows sustained increase (1.5 C and/or an increase in temperature to > 34 C) without evidence of thermal or tactile sensory block. Evidence of a Horner's response to upper extremity blocks should be documented. The use of sedation with the block can influence results, and this should be noted. (Krumova, 2011) (Schurmann, 2001) In this case, these tests are not indicated. This is secondary to inadequate clinical findings of autonomic dysfunction to warrant further evaluation. The criteria as listed above have not been met. As such, the request is not medically necessary.

**Chiropractic Therapy 2x a week for 4 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. The guidelines state the following: Low back: Recommended as an option. Therapeutic care: Trial of 6 visits over weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care: Not medically necessary. Recurrences/flare-ups: Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. In this case, the patient does not qualify for physical therapy as indicated above and would benefit most from at home active therapy. The patient's injury was in April of 2012. As such, the request is not medically necessary.

**Acupuncture 1x a week for 4 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder/Acupuncture.

**Decision rationale:** The request is for acupuncture of the shoulder. The MTUS guidelines do not specifically address this issue. The ODG state the following: Recommended as an option for rotator cuff tendonitis, frozen shoulder, subacromial impingement syndrome, and rehab following surgery. A review of 9 trials with varying placebo controls showed there was possibly some support for short-term benefit in regards to pain and function. (Green-Cochrane, 2005) Acupuncture was of benefit over placebo in terms of function, and was more effective when combined with exercise compared to exercise alone. Several small clinical trials have found acupuncture to be effective on shoulder pain, but referral is dependent on the availability of experienced providers with consistently good outcomes. Among those shoulder indications, found to have positive outcomes from acupuncture, were rotator cuff tendonitis, frozen shoulder, subacromial impingement syndrome, and rehab following arthroscopic acromioplasty. (Kleinhenz, 1999) (Sun, 2001) (Romoli, 2000) (Nabeta, 2002) (Gilbertson, 2003) (Guerra, 2003) (He, 2004) (Vickers, 2004) (Grant, 2004) (Michener, 2004) (Guerra de Hoyos, 2004) On the other hand, a recent trial did not show any benefit of acupuncture compared with placebo TENS when added to the exercise treatment of rotator cuff tendonitis. (Razavi, 2004) The results of this trial suggest that acupuncture is more efficacious than ultrasound when applied in addition to home exercises in patients with impingement syndrome. Both groups improved, but the acupuncture group had a larger improvement in the combined score. (Johansson, 2005) This recent RCT found that either electroacupuncture or interferential electrotherapy, in combination with shoulder exercises, is equally effective in treating frozen shoulder patients. It should be noted that this study only showed the combined treatment effects with exercise as compared to no treatment, so the entire positive effect could have been due to the use of exercise alone. (Cheing, 2008) Naturopathic treatment combining acupuncture, dietary counseling, and hydrolytic enzymes was more effective than physical exercise plus placebo for treating rotator cuff tendinitis, in a recent RCT. (Szczerko, 2009) Both subacromial corticosteroid injection and a series of 10 acupuncture treatments combined with home exercises significantly decreased pain and improved shoulder function in patients with subacromial impingement syndrome. (Johansson, 2011) The latest UK Health Technology Assessment on management of frozen shoulder concludes that there was insufficient evidence to make conclusions with any certainty about the effectiveness of acupuncture for primary frozen shoulder and in what situations it is likely to be effective. (Maund, 2012) For an overview of acupuncture and other conditions in which this modality is recommended see the Pain Chapter. ODG Acupuncture Guidelines: Initial trial of 3-4 visits over 2 weeks, with evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy). As stated above, there is no documentation of functional improvement after initial trial of acupuncture. This would be required prior to the request submitted. As such, it is not medically necessary.

**Pantoprazole tab 20mg 1 tab po bid #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** The request is for the use of a medication in the class of a proton pump inhibitor. It is indicated for patients with peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatories for chronic pain. Unfortunately, they do have certain side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically. Criteria for risk are as follows: (1) age > 65 years; (2) history of peptic ulcer,

GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Due to the fact the patient does not meet to above stated criteria, the request for use is not medically necessary.

**Sudo Scan:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment for Workers' Compensation, 13th Annual Edition, 2015.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diabetes/SudoScan.

**Decision rationale:** The request is for a Sudo scan. The official disability guidelines state the following regarding this topic: Not recommended, as there is a lack of evidence showing that this device improves patient management. See also Autonomic nervous system function testing in the Pain Chapter. The Sudoscan is an autonomic nervous system function test for sudomotor function. The autonomic nervous system regulates blood pressure, heart rate, temperature, respiration, gastrointestinal, bladder and sexual function. Autonomic nervous system testing can be grouped into three categories, sudomotor, cardiovagal innervation, and vasomotor adrenergic innervation. The tests for sudomotor function can include QSART, TST, SSR, Silasticsweat imprint, Sudoscan and QDIRT. The Sudoscan is a non-invasive method to measure sweat gland function. The device evaluates sweat gland function by obtaining electrochemical reaction between sweat chlorides and stainless-steel electrodes, and it measures electrochemical skin conductance of hands and feet through reverse iontophoresis. A study on the use of Sudoscan as a screening tool for microvascular complications in type-2 diabetes found that the sensitivity was 82% and the specificity was 61%, and for detection of peripheral neuropathy, sensitivity was 82% and specificity was 55%. The study had many limitations and there should be a follow-up study. Much of the literature is limited to small case series. In comparing Sudoscan to conventional measures of peripheral and cardiac neuropathy, authors conclude that the Sudoscan is not a substitute for conventional neuropathy testing. There is a paucity of evidence documenting how these autonomic tests change management or impact treatment in clinical disorders associated with autonomic nervous systems dysfunction. (Calvet, 2013) (Casellini, 2013) (Eranki, 2013) (Nevoret, 2015) (Raisanen, 2014) (Smith, 2014) As indicated above, this test would not be supported by the guidelines. This is secondary to poor clinical evidence revealing how the results impact the treatment rendered. As such, the request is not medically necessary.

**Functional Capacity Evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fit for Duty/Functional capacity evaluation.

**Decision rationale:** The request is for a functional capacity evaluation. The MTUS guidelines are silent regarding this issue. The ODG state the following: Guidelines for performing an FCE: Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. If a worker is actively participating in determining

the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if: 1) Case management is hampered by complex issues such as: Prior unsuccessful RTW attempts. Conflicting medical reporting on precautions and/or fitness for modified job. Injuries that require detailed exploration of a worker's abilities. 2) Timing is appropriate: Close or at MMI/all key medical reports secured. Additional/secondary conditions clarified. Do not proceed with an FCE if: The sole purpose is to determine a worker's effort or compliance. The worker has returned to work and an ergonomic assessment has not been arranged. (WSIB, 2003) In this case a functional capacity evaluation is not indicated. There is inadequate documentation of the patient and employer actively participating in determining the suitability of a particular job. As such, the request is not medically necessary.

**Interferential Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Interferential current therapy (IFC).

**Decision rationale:** The request is for the use of Interferential current therapy (IFC). The MTUS guidelines are silent regarding this issue. The ODG guidelines state the following: Under study for osteoarthritis and recovery post knee surgery. Not recommended for chronic pain or low back problems. After knee surgery, home interferential current therapy (IFC) may help reduce pain, pain medication taken, and swelling while increasing range of motion, resulting in quicker return to activities of daily living and athletic activities. (Jarit, 2003) See also the Pain Chapter. A recent industry-sponsored study concluded that interferential current therapy plus patterned muscle stimulation (using the RS-4i Stimulator) has the potential to be a more effective treatment modality than conventional low-current TENS for osteoarthritis of the knee. (Burch, 2008) In this case the patient does not qualify for the use of this product as it is not advised for any condition including low back pathology. It is under study for the recovery post knee surgery. It is not advised for chronic pain. As such, the request is not medically necessary.

**Urinalysis Test for Toxicology:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**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)/Urine drug testing (UDT).

**Decision rationale:** The request is for a urine drug screen. The ODG states the following regarding this topic: 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. The frequency of drug testing is indicated below: 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. 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. 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. In this case, a urine drug screen is not supported by the guidelines. This is secondary to inadequate documentation of risk level commensurate to the frequency of evaluation requested. As such, it is not medically necessary.