

<b>Case Number:</b>	CM15-0046505		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	06/05/2003
<b>Decision Date:</b>	04/23/2015	<b>UR Denial Date:</b>	03/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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, 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 is a 52 year old male who sustained a work related injury June 5, 2003. According to a primary treating physician's progress report, dated February 25, 2015, the injured worker presented with complaints of lower back pain and numbness radiating to his bilateral lower extremities and into his feet. The pain is rated 9/10 without medication and 3-4/10 with medication. Current medication includes Percocet, Lunesta, Lyrica and Proair. Diagnoses included s/p electrical shock; heart palpitations; strain/sprain of the cervical spine, superimposed upon a 5 mm disc at C5-6 and 2-3mm disc at C6-7 and disc disease at C5-6 and C6-7; s/p left shoulder subacromial decompression and debridement of SLAP lesion and bursectomy of the left shoulder with distal clavicle excision; s/p right carpal tunnel release; s/p right ulnar nerve release; s/p hematoma excision, right arm; subluxing left ulnar nerve; s/p incision and drainage, left elbow, post-op MRSA; s/p anterior cervical decompression and fusion (ACDF); s/p L2-3, L3-4 discectomy and anterior lumbar interbody fusion; L3 burst fracture post-surgery; s/p lumbar revision; removal of lumbar hardware March 2013; and medial meniscus tear, right knee. Treatment plan included review of pain/medication management and consultation, urine drug screen performed, continue home exercise, and prescription for Percocet.

### 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter, Drug Testing (UDT).

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

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, urine drug testing 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. In this case, the injured worker's working diagnoses are status post electric shock; heart palpitations; strain sprain cervical; status post left shoulder subacromial decompression and debridement SLAP and bursectomy of left shoulder with distal clavicle resection; headache; status post right carpal tunnel release; right hand burns; status post right ulnar release; status post excision hematoma; status post I & D; status post ACDF; status post L2-L3 and L3 L4 discectomy with interbody fusion; L3 burst fracture status post surgery; status post lumbar fusion; status post lumbar revision; removal lumbar hardware; and medial meniscus tear right knee. The documentation shows a urine drug screen (UDS) was ordered September 23, 2014. The injured worker was taking Percocet and the UDS was consistent for Percocet. A repeat urine drug screen was performed January 26, 2015. The injured worker was taking Percocet and the UDS was consistent for Percocet. In a progress note dated February 25, 2015, a third urine drug screen was requested to check for medication compliance. The two prior urine drug toxicology screens (last one performed one month prior) were consistent with Percocet. There was no aberrant drug-related behavior, drug misuse or abuse. There was no risk assessment in the medical record indicating whether the injured worker was a low risk, intermediate or high risk for drug misuse or abuse. However, the two prior urine drug screens are consistent with the drugs being taken. There is no clinical indication and no clinical rationale to repeat urine drug screen a third time. Consequently, absent compelling clinical documentation with two prior consistent urine drug toxicology screens and no risk assessment in the record, urine drug testing is not medically necessary.