

Case Number:	CM13-0020952		
Date Assigned:	10/11/2013	Date of Injury:	10/08/2002
Decision Date:	02/04/2014	UR Denial Date:	08/23/2013
Priority:	Standard	Application Received:	09/06/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal and is licensed to practice in the District of Columbia. 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 physician 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:

The patient had an industrial injury on 10/08/2002. The mechanism of injury was not given. Her history was significant for L5-S1 root foraminal decompression needle facetectomy 2006, status post ankle fracture right side, ORIF 4/10/08, status post removal right ankle hardware 6/1/2009. Her evaluation included MRI of lumbar spine in 2002 and 2003 that showed lumbar canal stenosis and disc extrusion at L5-S1. Her treatment included two epidural steroid injections which provided her a 60% pain relief. Medications included Percocet, Lyrica, Norco, Omeprazole, Cartivisc and Tizanidine. She was seen by the treating provider on 04/25/13. She complained of low back pain rated 6/10. On examination antalgic gait was present. There was diffuse tenderness to palpation of the lumbar paraspinal muscles and there was moderate facet tenderness was noted at L4-S. There is decreased sensation at L4 and L5 dermatomes on the right side and at the L4 dermatome on left side with limited lumbar flexion at 60 degrees. Her diagnosis included status post lumbar laminectomy, lumbar disc disease, lumbar radiculopathy, lumbar facet arthropathy and status post ankle fracture open reduction and internal fixation. She was recommended to get a third epidural steroid injection, continue Percocet PO and home exercises. A urine drug testing was done. She was seen previously by the treating provider in February 2013, December 2012 and October 2012. During both visits, there is documentation of plans to obtain urine drug testing. But there is no mention of the results of the tests during the subsequent visits. There is no aberrant behavior seen in the claimant.

IMR ISSUES, DECISIONS AND RATIONALES

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

urine drug screening provided on 5/12/12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain, Urine Drug Testing.

Decision rationale: In this case, patient was being treated for chronic low back pain with Opioids. She was being seen every 2 months approximately by the treating provider and there is documentation of urine drug testing in plan of care during each visit. Results are unavailable except for the urine drug testing in April 2013. Also there is no mention about the previous tests in the subsequent progress notes. There is no mention of aberrant behavior in the progress notes. Hence urine drug testing at a frequency of every 2 months is not medically necessary.