

Case Number:	CM13-0049679		
Date Assigned:	12/27/2013	Date of Injury:	04/13/2012
Decision Date:	02/28/2014	UR Denial Date:	10/21/2013
Priority:	Standard	Application Received:	11/08/2013

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 Family Practice, 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 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 is a 55-year-old female who reported an injury on 04/13/2012. The mechanism of injury was a fall. The patient's initial course of treatment included chiropractic therapy as well as activity modification, work restrictions, and medications. Despite conservative treatment, the patient's symptoms to her cervical spine, right shoulder, right wrist and hand, upper mid back, low back, and left knee were persistent. An MRI of the lumbar spine performed 07/04/2012 revealed chronic abnormal bio-mechanical stress at the left L5 pedicle, an S2 hemangioma, L5-S1 facet osteoarthritis, a 2 mm disc bulge on extension only to L2-3, a 2 mm disc bulge on extension only to L3-4, a grade I degenerative spondylolisthesis at L4-5, and degenerative disc disease throughout. A cervical MRI performed on 06/04/2012, revealed a 1 mm disc protrusion at C4-5 and a 2 mm disc protrusion and degenerative disc disease at C5-6 and contacting the cord, and a 1.1 cm right thyroid cyst. An NCV performed on 07/01/2012, revealed early carpal tunnel syndrome. An EMG of the bilateral upper extremities performed on 07/01/2012 revealed right C7 radiculopathy. The most recent list of medications were obtained from the 11/19/2013 clinical note and include Flurbiprofen cream 20%, Keto rub-lido cream 20%/10%, Vicodin ES 7.5 mg/750 mg, Anaprox DS 550 mg, Celexa 20 mg, Orphenadrine citrate ER 100 mg, Prilosec 20 mg, and Colcrys 0.6 mg. Other treatments that the patient has been referred for include acupuncture. According to the clinical examination performed on 07/03/2013, the patient's medications at that time were Colightsin, Prilosec, Celexa, Hydrocodone, Tylenol, vitamin, and Zofran. There was no other pertinent information submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 urine drug screen done 7/3/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Urine Drug Testing

Decision rationale: The California MTUS/ACOEM Guidelines recommend urine drug screening to monitor patient compliance with opioid and narcotic medications. However, the California MTUS/ACOEM Guidelines did not specifically address the frequency with these urine drug screens should be administered; therefore, the Official Disability Guidelines were supplemented. Official Disability Guidelines state that the frequency of urine drug screens should be performed according to the results of a risk stratification test. Patients completing this test will be placed into either a low, moderate, or high risk category for aberrant drug behaviors. Patients in the low category need to be tested once yearly; patients in the moderate category should be tested 2 to 3 times a year; and patients in the high risk category need to be tested up to monthly. The clinical records submitted for review did not provide any documentation that a risk stratification test had been performed, nor did it discuss the patient's drug behaviors or possible risk factors. As of the 07/03/2013 urine drug test, the patient had already received urine drug testing at least 2 times, and she was tested at least 3 times after that. Without discussion of the patient's risk factors, guideline compliance and medical necessity cannot be determined at this time. As such, the request for one urine drug screen done on 07/03/2013 is non-certified.