

Case Number:	CM13-0057992		
Date Assigned:	12/30/2013	Date of Injury:	03/20/2009
Decision Date:	03/25/2014	UR Denial Date:	11/04/2013
Priority:	Standard	Application Received:	11/26/2013

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 Medicine, 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 63 year old female who sustained an injury involving the head, neck, lumbar spine and right ankle while at work. The patient was on a ladder reaching to grab a box when a box fell. Treatment history included a cortisone injection to the right ankle which was set in a cast. On April 24, 2012, the patient had surgery to the right ankle and attended 12 sessions of post-operative physical therapy. The patient also treated with acupuncture treatment. Magnetic Resonance Imaging (MRI) of the lumbar spine dated 03/22/2013 revealed a disc bulge at L1-L2 measuring 1-2mm. There was mild central spinal canal stenosis. There was broad-based central disc protrusion at L2-L3 measuring 2 mm with mild central spinal canal stenosis. There was broad-based central disc protrusion at L3-L4 measuring approximately 2-3mm. There was an annular tear and mild narrowing of the caudal margin of the neural foramen bilaterally. There was mild central spinal canal stenosis and a bilateral facet arthropathy. There was a broad based central disc protrusion at L4-L5 measuring 3mm with an annular tear was shown. There was moderate narrowing of the caudal margin of the orifice of the neural foramen bilaterally. There was bilateral facet arthropathy and mild to moderate central spinal canal stenosis. L5 may have represented a transitional vertebrae. A diagnostic study dated 10/02/2013 noted there was a urine toxicology review was negative. A clinic notes from 10/2/2013 revealed the following from the examination: Right foot: alignment was normal; plantar grade with bunionette deformity. There was soft tissue swelling, slight at hindfoot. There were wounds/incisions/scars which included a healed 6 cm lateral hindfoot scar and a healed 1 cm incision at the heel. There was no atrophy. Left foot: alignment was normal plantar grade. There was no soft tissue swelling, wound/incision/scar nor atrophy. Palpation showed right foot had tenderness with bunionette and a lateral hindfoot, with no tenderness for the left. Range of motion: Right showed R Dorsiflexion (EN 20°) 15°, R Plantar Flexion (EN 46°) 30°, R Subtalar Joint Inversion

(EN 22°) 0, R Subtalar Joint Eversion (En 12°). Left showed: L Dorsiflexion (EN 20°) 20°, L Plantar Flexion (EN 46°) 46°, L Subtalar Joint Inversion (EN 22°) 22° L Subtalar Joint Eversion (EN 12°) 12°. Neurologic showed both right and left ankle/foot sensation normal to light touch. Pulses were 2+ bilateral. Motor Strength: Right: Dorsiflexion: 5/5, Plantar Flexion 5/5, Subtalar Joint Inversion cannot be tested, Subtalar Joint Eversion cannot be tested, toes Dorsiflexion/Plantar Flexion 5/5. Left: Dorsiflexion 5/5, Plantar Flexion 5/5, Subtalar Joint Inversion 5/5, Subtalar Joint Eversion 5/5 and toes Dorsiflexion/Plantar Flexion 5/5. Stability testing revealed right and left anterior drawer testing was negative. Percussion tests revealed Tinel's test both right and left negative over the tarsal tunnel.

IMR ISSUES, DECISIONS AND RATIONALES

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

(6) panel urine drug screen preformed on 10/2/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

Decision rationale: As per CA MTUS and ODG guidelines, urine drug testing (UDT) is 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. The provider's note from 10/02/2013 does not indicate any prescribed medications instead taking over the counter pain medication, which does not require compliance monitoring through urine drug screening. Therefore, the medical necessity for six (6) panel urine drug screen has not been established and hence the request is non-certified.