

Case Number:	CM14-0073546		
Date Assigned:	07/16/2014	Date of Injury:	01/30/2013
Decision Date:	09/16/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/20/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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/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 53-year-old female who has submitted a claim for cervical myospasm, cervical degenerative joint disease/degenerative disc disease, lumbar degenerative joint disease/degenerative disc disease, and lumbar myospasm associated with an industrial injury date of January 30, 2013. Medical records from 2013-2014 were reviewed. The patient complained of headache rated 7/10, neck pain 9/10, and back pain 9/10. The pain was associated with weakness, numbness, giving way, locking, grinding, and swelling. The pain radiates to her jaws, eyes, chest, abdomen, ribs, buttocks, shoulders, upper arms, forearms, wrists, hands, fingers, hips, legs, knees, ankles, feet, and toes. She reports that overhead reaching, lifting, pushing, pulling, twisting, bending, stooping, walking, and sitting aggravate her symptoms. Physical examination showed tenderness over the paravertebral region. There was 4/5 strength with flexion, extension, bilateral rotation, and bilateral lateral flexion. Range of motion was restricted due to pain. Lumbar spine examination showed tenderness over the paravertebral region bilaterally. Motor strength was 4/5 with flexion, extension, and bilateral lateral bend. Range of motion was restricted due to pain. MRI of the cervical spine dated July 16, 2013 revealed mild degenerative changes without significant neuroforaminal narrowing or effacement of CSF spaces. MRI of the lumbar spine, dated June 7, 2014, showed slight retrolisthesis of L5 with a 3mm disc bulge, foraminal narrowing, and facet hypertrophy; 2mm disc bulges with foraminal narrowing and facet hypertrophy from L2-L3 to L4-L5; and 2mm disc bulge at T11-T12. Treatment to date has included medications, physical therapy, acupuncture, psychotherapy, TENS unit, home exercise program, activity modification, lumbar epidural steroid injection, Utilization review, dated May 5, 2014, denied the request for urine drug screen because there was no patient data to demonstrate medical necessity or any objective evidence of cause; and

denied the request for Toradol 60mg IM because there was there was no medical necessity for intramuscular delivery of NSAIDs versus the oral route.

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: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

Decision rationale: As stated on CA MTUS ACOEM Guidelines for the Chronic Use of Opioids, routine use of urine drug screening for patients on chronic opioids is recommended as there is evidence that it can identify aberrant opioid use. Screening should also be performed "for cause", i.e. with provider suspicion of substance misuse. In this case, the documented rationale for the request was because the patient was being evaluated for medication management and/or ongoing medication therapy. However, progress report dated March 4, 2014 state that the drug screen was administered to the patient and results will follow during the next appointment. No urine drug screen results were reported on the medical records submitted. Furthermore, submitted medical records did not document non-compliance from prescribed medications. There was also no suspicion of substance misuse from the physician. Furthermore, progress report dated June 2, 2014 state that current medications do not include opioid medications. The medical necessity has not been established. Therefore, the request for Urine Drug Screen is not medically necessary.