

Case Number:	CM14-0202184		
Date Assigned:	12/12/2014	Date of Injury:	04/10/2012
Decision Date:	01/29/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/03/2014

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 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 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 injured worker (IW) is a 48-year-old woman with a date of injury of April 10, 2012. The mechanism of injury was not documented in the medical record. The injured worker's working diagnoses are bilateral shoulder impingement; trapezius sprain/strain; and bilateral wrist tenosynovitis. The remainder of the diagnoses is illegible. Pursuant to the sole handwritten, largely illegible progress note dated October 23, 2014, the IW complains of stomach pain with diarrhea. She also has low back pain with soreness and spasms. Examination of the bilateral wrists reveals tenderness to palpation. Examination of the lumbar spine reveals tenderness to palpation with guarding and spasms. Positive straight leg raise test on the right was noted. The remainder of the subjective and objective documentation is illegible. There were no medications documented. There is a check box on page 3 of the 10/23/14 progress note indicating urine drug screen (UDS) result reviewed with patient and demonstrates medication compliance with prescribed medications. The current request is for (1) UDS results reviewed with patient.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine drug screen results reviewed with patient: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section, Urine Drug Testing.

Decision rationale: Pursuant to the Official Disability Guidelines, urine drug screen results reviewed with patient is not medically necessary. Urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncovered the 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 frequency of urine drug testing is determined by whether the injured worker is a low risk, intermediate risk or high risk for drug misuse or abuse. In this case, the documentation contains handwritten progress notes that largely illegible. The legible diagnoses are bilateral shoulder impingement; trapezius sprain/strain; and bilateral wrist tenosynovitis. The illegibility pertains to the subjective, objective and diagnostic entries in the medical record. On page 3 of the progress note dated October 23, 2014, there was a checkbox checked off indicating the urine drug screen was compliant with the patient medications. There was no documentation of aberrant drug-related behavior, drug misuse or abuse or risk assessment indicating drug misuse or abuse. Additionally, urine drug testing was consistent with the medications being taken. The documentation does not contain a list of the medications being taken. Consequently, absent the appropriate clinical documentation (legibility), a list of prescription medications being taken, the clinical indication for urine drug screen, and a consistent urine drug screen outcome, the urine drug screen results reviewed with patient is not medically necessary.