

Case Number:	CM15-0181906		
Date Assigned:	09/23/2015	Date of Injury:	07/08/2002
Decision Date:	10/27/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/15/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New Jersey, New York
 Certification(s)/Specialty: Family Practice

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 is a 44 year old female, who sustained an industrial-work injury on 7-8-02. She reported initial complaints of neck and low back pain. The injured worker was diagnosed as having cervical radiculopathy, lumbar radiculopathy, and cervical discogenic disease. Treatment to date has included medication and ESI (epidural steroid injection) on 3-23-15. Currently, the injured worker complains of neck and lower back pain. Pain decreases with medications and increases her functionality as well as help her with the ADL's (activities of daily living). Pain is 8-9 out of 10 without mediation and 4-5 with medication. Meds include Norco, Soma, and Motrin. Per the primary physician's progress report (PR-2) on 6-23-15, exam noted limited range of motion to the neck, pain that radiates into the left upper extremity, pain with extension and rotation of the lumbar spine, straight leg raise is positive in the left lower extremity, positive Lasegue sign on the left, radicular pain at L5-S1, S1 greater than L5 on the left. Current plan of care includes refill medication (Norco for pain, Motrin for inflammation, and Soma for muscle spasms) and physical therapy. The Request for Authorization requested service to include Urinalysis and TENS (transcutaneous electrical nerve stimulation) unit & supplies (rental or purchase). The Utilization Review on 9-8-15 partial certification: to 10 panel random drug screen for qualitative analysis (either through point of care testing) with confirmatory laboratory testing only performed in inconsistent results x1 due to support and non-certification of TENS unit and supplies (rental or purchase) due to no documentation of significant change in status or function, per CA MTUS (California Medical Treatment Utilization Schedule) Guidelines and ODG (Official Disability Guidelines).

IMR ISSUES, DECISIONS AND RATIONALES

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

Urinalysis: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain - Urine Drug Testing (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing, Opioids, criteria for use.

Decision rationale: The request for a urine drug screen is considered medically necessary. The patient's medications included opioids and in order to monitor effectively, the 4 As of opioid monitoring need to be documented. This includes the monitoring for aberrant drug use and behavior. One of the ways to monitor for this is the use of urine drug screens. The UR states there was no provider concerns for illicit drug use or non-compliance. However, because of the abuse potential of opiates, it is reasonable to monitor with urine drug screens. Therefore, I am reversing the prior UR decision and consider this request to be medically necessary.

TENS (transcutaneous electrical nerve stimulation) unit & supplies (rental or purchase):
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, TENS.

Decision rationale: The request is not medically necessary. The use of TENS unit is reasonable as an adjunct to a functional restoration program when other conservative appropriate pain modalities have failed. The patient had improvement with the use of the TENS, however, specific improvement in function was not documented. There was also no documentation of reduction in medication with the use of TENS unit. As per MTUS guidelines, TENS "does not appear to have an impact on perceived disability or long-term pain" in the management of chronic low back pain. Therefore, the request is considered not medically necessary.