

<b>Case Number:</b>	CM15-0190403		
<b>Date Assigned:</b>	10/02/2015	<b>Date of Injury:</b>	03/03/2009
<b>Decision Date:</b>	11/10/2015	<b>UR Denial Date:</b>	09/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/28/2015

### 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: Arizona, California

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 55-year-old female, with a reported date of injury of 03-03-2009. The diagnoses include cervical disc degeneration, with facet arthropathy and moderate central stenosis at C5-6; right lateral epicondylitis; complex regional pain syndrome of the right lower extremity; right knee pes anserinus tendonitis; status post L3-4 and L4-5 transforaminal interbody fusion; right leg radiculopathy; right arm radiculopathy; right knee internal derangement, rule out meniscus tear; lumbar disc degeneration with positive concordant pain on discography; lumbar stenosis; lumbar radiculopathy; and status post removal of hardware. Treatments and evaluation to date have included Norco, lumbar discography on 04-20-2010, right stellate ganglion block on 09-21-2010, and a lumbar transforaminal interbody fusion on 05-12-2011. The diagnostic studies to date have not been included in the medical records provided. The progress report dated 08-05-2015 indicates that the injured worker complained of right shoulder pain, which radiated down the right upper extremity. She rated the pain 5 out of 10. The injured worker also complained of low back pain with radiation down the right lower extremity, which was rated 6 out of 10. The injured worker had difficulty with some of her activities of daily living. The physical examination showed an antalgic gait; tenderness to palpation of the lumbar paravertebral muscles, bilaterally; no tenderness over the sciatic notches or over the sacroiliac joints, bilaterally; no tenderness over the coccyx; and mildly decreased sensation over the right L4, L5, and S1 dermatomal distribution. It was noted that the injured worker underwent an MRI of the right knee on 05-23-2011 which showed possible meniscal injury; electrodiagnostic studies of the lower extremities on 11-09-2009 which showed right L5-

S1 and left S1 radiculopathy versus mild spinal stenosis; an MRI of the lumbar spine on 11-17-2009 which showed posterior disc bulges, mild to moderate central canal narrowing with annular fissures, bilateral facet hypertrophy, and mild bilateral L4-5 neural foraminal narrowing; x-rays of the right elbow on 08-08-2011 which showed a possible bone chip of the superior to radial head; a CT scan of the lumbar spine on 04-20-2010 which showed posterior disc bulge, mild multi-factorial central canal stenosis and right neural foraminal encroachment; a CT scan of the lumbar spine on 06-07-2012; an MRI of the lumbar spine on 06-12-2012; an MRI of the cervical spine on 03-20-2013; an MRI of the right knee on 03-20-2013; electrodiagnostic studies of the bilateral upper extremities on 03-20-2013; an x-rays of the right elbow on 03-21-2013 with normal findings; x-ray of the lumbar spine on 04-21-2014 which showed spondylosis at L5-S1; and x-rays of the left elbow on 04-21-2014 with well-maintained joint spaces. The treating physician noted that the injured worker may have undergone a random urine toxicology screening to verify medication compliance. The injured worker's work status was not indicated. The treating physician requested a urine drug screen (date of service: 08-07-2015). On 09-18-2015, Utilization Review (UR) non-certified the request for a urine drug screen (date of service: 08-07-2015).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Retrospective request for Urine Drug Screen, DOS: 08/07/15: 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): Opioids, screening for risk of addiction (tests).

**Decision rationale:** According to the California MTUS Chronic Pain Treatment Guidelines, urine toxicology screen is used to assess presence of illicit drugs or to monitor adherence to prescription medication program. There is no documentation from the provider to suggest that there was illicit drug use or noncompliance. There were no prior urine drug screen results that indicated noncompliance, substance-abuse or other inappropriate activity. Based on the above references and clinical history a urine toxicology screen is not medically necessary.