

Case Number:	CM14-0216378		
Date Assigned:	01/06/2015	Date of Injury:	03/19/2008
Decision Date:	03/03/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/24/2014

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. 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, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 57 year old female continues to complain of cervical pain with upper extremity numbness and tingling stemming from cumulative work related trauma reported on 3/19/2008 - 3/19/2009. Diagnoses include: cervical disc disease; cervical radiculopathy; cervical facet syndrome; and nerve root compression on MRI. Treatments have included: consultations; diagnostic imaging studies; bracing, thumb splints; occupational therapy; physical therapy for the neck & upper back only with home exercise program and rest; chiropractic manipulation; injection therapy to the left wrist and bilateral knees; bilateral feet orthotics; and medication management. The injured worker (IW) was noted to be back at work, with restrictions, as of 6/10/2014. An MR of the cervical spine, dated 4/6/2013, noted retrolisthesis of cervical 4 on 5, degenerative changes with resulting effacement of the ventral cerebral spinal fluid and mild distortion of the cord, without distortion; and severe right C4-5 neural foraminal stenosis and mild foraminal narrowing. The 4/7/2014 Supplemental qualified medical evaluation stated this IW had pre-existing degenerative changes in her neck, knees and thumbs not caused by specific or repetitive industrial injuries, and that 50% of her symptomatology is related to that; leaving 50% to the industrial claim for these body parts. As for the symptomatology of the neck; cervical, thoracic and lumbar spine; bilateral upper and lower extremities; shoulders; and right hip, that these may be a result cumulative work trauma if the IW was performing her usual and customary duties between 8/24/201 and 8/24/2012. Noted is an 8/15/2014 MRI of the cervical spine that noted diffuse heterogeneous, underlying marrow infiltrative or replacing process was considered and needed ruling out; correlated whole body nuclear scan and laboratories were recommended. Orthopedic

notes dated 9/3/2014 refer to a work related injury sustained on 3/26/2012 and in 4/2012, as well as worsening cumulative trauma injury extending from 3/19/2008 - 3/19/2009. The chief complaint was for cervical spine pain rated 7/10, along with multiple other related issues. Noted was this IW did not report her persistent complaints to her employer until 10/2009. Noted are: a history of right leg vascular surgery; that the IW is not currently taking medications for her noted conditions; joint pain in the lumbar region; abnormal findings and some deficits in examination to the cervical spine, right shoulder, shoulder and elbow abductor muscles, and upper extremity bicep and brachioradialis reflexes. The treatment plan included multi-level epidural steroid injections; continuing her present medications (not listed); random urine toxicology screening to establish a baseline and ensure compliance with medications, and eliminate the risk of taking medications from multiple sources or using illicit drugs; and a cervical traction unit. No medications were either noted or ordered. A Urine toxicology screen is noted collected on 9/3/2014. Noted is a 9/18/2014 an MRI of the right knee that is illegible. The remaining medical records available for my review are dated 12/12/14, 12/17/14, and 1/26/15 after utilization review. On 10/27/2014 Utilization review non-certified, for medical necessity, the request for a retrospective urine drug screen stating that the IW was not currently taking medications for the above noted conditions and the IW should continue on her current medication regimen. Cited were the MTUS guidelines for chronic pain medical treatment guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Urine drug screen (DOS 9/18/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction, Page(s): 77-78; 94.

Decision rationale: According to MTUS guidelines, urine toxicology screens is indicated to avoid misuse/addiction. Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs. In this case, there is no documentation of drug abuse or aberrant behavior. There is no documentation of drug abuse or misuse. There is no rationale provided for requesting UDS test. Therefore, Urine Drug screen is not medically necessary.