

<b>Case Number:</b>	CM13-0054295		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	01/14/2012
<b>Decision Date:</b>	06/27/2014	<b>UR Denial Date:</b>	11/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/19/2013

### 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 Emergency Medicine, and is licensed to practice in New York. 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 44 year old male who was injured on January 14, 2012. The patient continued to experience left shoulder and back pain. Physical examination was notable for tenderness of the left sternoclavicular and acromioclavicular joints, decreased range of motion of the left shoulder, and paraspinal tenderness of the lumbar spine. Diagnoses included left shoulder impingement syndrome, left shoulder rotator cuff syndrome, lumbar sprain/strain, and lumbar spine disc herniation without myelopathy. Requests for authorization for acupuncture for 8 treatments, urinalysis for toxicology, TENS unit for home use, and aqua therapy unit for home use were submitted for consideration.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **ACUPUNCTURE TREATMENT 2 TIMES PER WEEK FOR 4 WEEKS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACUPUNCTURE TREATMENT GUIDELINES, ,

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The MTUS Acupuncture Guidelines indicate Acupuncture is used as an option when pain medication is reduced or not tolerated or as an adjunct to physical

rehabilitation. Acupuncture with electrical stimulation is the use of electrical current on the needles at the acupuncture site. Acupuncture is recommended when use as an adjunct to active rehabilitation. Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: 1) Time to produce functional improvement: 3 to 6 treatments. 2) Frequency: 1 to 3 times per week. 3) Optimum duration: 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. In this case the patient's treatment should be a trial of 3-6 visits to determine if functional improvement is obtained. If functional improvement is not obtained, then the treatments should be discontinued. The request for 8 treatments surpasses the maximum number of treatments recommended for an acupuncture trial. The request is not medically necessary and appropriate.

#### **URINALYSIS FOR TOXICOLOGY AND COMPLIANCE TO MEDICATIONS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, URINE DRUG SCREEN,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines

**Decision rationale:** The MTUS Chronic Pain Guidelines state that urinary drug testing should be used if there are issues of abuse, addiction, or pain control in patients being treated with opioids. The ODG criteria for Urinary Drug testing are recommended for patients with chronic opioid use. Patients at low risk for addiction/aberrant behavior should be tested within 6 months of initiation of therapy and yearly thereafter. Those patients with moderate risk for addiction/aberrant behavior should undergo testing 2-3 times/year. Patients with high risk of addiction/aberrant behavior should be tested as often as once per month. In this case there is no documentation that the patient is using opioids chronically. In addition there is no aberrant behavior. The request is not medically necessary and appropriate.

#### **TENS UNIT FOR HOME USE:**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS),

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-115.

**Decision rationale:** TENS units are not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, including reductions in medication use, for neuropathic pain, phantom limb pain, spasticity, and multiple sclerosis. There must be evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented with

documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. In this case the patient was about to receive a trial of acupuncture. There was no evidence of treatment failure with the acupuncture. In addition there had been no trial of TENS unit to determine if the TENS unit treatment would produce a positive outcome. Therefore, the request is not medically necessary and appropriate.

**CONTRAST AQUA THERAPY UNIT FOR HOME USE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

**Decision rationale:** Contrast aqua therapy is hot/cold immersion therapy. Home local application of cold is recommended during the first few days of acute complaints. Heat application is recommended thereafter. There is no comment on a home unit for immersion hot/cold therapy. Ice packs and warming devices such as a heating pad should be sufficient. The request is therefore not medically necessary and appropriate.