

<b>Case Number:</b>	CM14-0075947		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	06/03/1998
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	05/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/23/2014

### 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 Physical Medicine & Rehab, has a subspecialty in Interventional Spine 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 patient is a 64 years old female with an injury date on 06/03/1998. Based on the 02/03/2014 handwritten progress report provided by [REDACTED], the patient presents with neck and back pain. The diagnoses were not provided in this report. Per treater, the patient had cortisone injection to the right shoulder 4 weeks ago; 75-90% improvement was noted. Asymmetric motion was noted in the cervical and lumbar spine. Tenderness was noted at the cervical muscle right side more than left side and lumbar muscle left side more than right side. The straight leg raise test was positive on the left. There were no other significant findings noted on this report. [REDACTED] is requesting: 1. Bilateral shoulder ultrasound. 2. Homecare 4 hours/day for 7 days a week for 6 weeks. 3. Review of drug screen. The utilization review denied the request on 05/08/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 10/11/2013 to 07/08/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Shoulder Ultrasound:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter; Ultrasound, diagnostic.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) U/S of the shoulder for diagnostic use.

**Decision rationale:** According to the 02/03/2014 report by [REDACTED] this patient presents with neck and low back pain. The treater is requesting bilateral shoulder ultrasound. The UR denial letter state "there is no clear exam findings outlined shoulder pathology, such as a rotator cuff tear, that would support the requested ultrasound." The MTUS and ACOEM guidelines do not discuss ultrasound. However ODG references a recent review that suggests "clinical examination by specialists can rule out the presence of a rotator cuff tear, and that either MRI or ultrasound could equally be used for detection of full-thickness rotator cuff tears, although ultrasound may be better at picking up partial tears." Review of the reports do not show any shoulder exam findings and the treater does not discuss what he is looking for with U/S. However, ODG guidelines do support U/S as a diagnostic tool and given the patient's persistent shoulder problems, and the reports do not show that the patient has any diagnostics to look at the rotator cuff such as an MRI. The request is medically necessary.

**Home Care 4 hours /day x7 days wk x6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Home Health services.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services.

**Decision rationale:** According to the 02/03/2014 report by [REDACTED] this patient presents with neck and low back pain. The treater is requesting homecare 4 hours/day, for 7 days a week, for 6 weeks. The UR denial letter states "There is no documentation of adverse medication side effects or evaluation and discharge summary from the previously certified home health care noting deficits that would require ongoing health care." The time frame of the previous home care was not provided. Regarding the provider's request for home care, MTUS guidelines page 51, recommend medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. The MTUS guidelines typically do not consider homemaking services such as shopping, cleaning, laundry, and personal care, and medical treatments. On the 03/28/2014 report indicates the patient "appears to be able to care for self at this time." There were no discussions regarding the patient's function at home. If the patient needs medical treatment on a part-time or "intermittent" basis and is homebound then the request for homecare would be reasonable. However, the treater does not explain what the 4 hours per day is to include for home care. The request is not medically necessary.

**Review of Drug Screen:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Pain Chapter; Criteria for Use of Urine Drug Testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines have the following regarding Urine Drug Screen.

**Decision rationale:** According to the 02/03/2014 report by [REDACTED] this patient presents with neck and low back pain. The treater is requesting a review of drug screen. The UR denial letter states "The requested of a review of the UDS includes the duplicate request of the requested urine sample and is considered medically necessary and are certified." While MTUS Guidelines do not specifically address how frequent UDS should be obtained for various risks of opiate users, ODG Guidelines provide clearer recommendation. It recommends a once a year urine screen following initial screening within the first 6 months for management of chronic opiate use in a low risk patient. In this case, medical records indicate the patient has not had any recent UDS, and the patient is noted to be on methadone, an opiate, since 10/16/2013. Therefore, UDS would be reasonable. However, the treater has asked for "review of the drug screen," but this is something that can be done as part of follow-up evaluation. It is not known why the treater has asked for this service separately when it can and should be performed as part of follow-up evaluation for opiates management. The request is not medically necessary.