

<b>Case Number:</b>	CM14-0092457		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	07/15/2012
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	05/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2014

### 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 and Rehabilitation and is licensed to practice in Nevada. 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 injured worker is a 45-year-old gentleman who was reportedly injured on July 15, 2012. The mechanism of injury is not listed in these records reviewed. The most recent progress note dated March 7, 2014, indicates that there are ongoing complaints of neck pain, left shoulder pain, and low back pain. The physical examination demonstrated tenderness over the acromioclavicular joint and sternoclavicular joint as well as the anterior capsule of the left shoulder. There was a negative apprehension test and O'Brien's test. As well as a mildly positive Neer's test and Hawkins test. There was decreased range of motion with abduction and forward flexion. Diagnostic imaging studies were not reviewed during this visit. Previous treatment is unknown. A request was made for a urinalysis for screening , a Pro-Stim unit, and a home exercise kit and was not certified in the pre-authorization process on May 23, 2014.9415

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective urinalysis for screening.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, screening for risk of addiction (screening).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Drug testing MTUS (Effective July 18, 2009) Page(s): 43 of 127.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines support urine drug screening as an option to assess for the use or the presence of illegal drugs; or in patients with previous issues of abuse, addiction or poor pain control. Given the lack of documentation of high risk behavior, previous abuse or misuse of medications, the request for a retrospective urinalysis for screening is not medically necessary.

**Pro-Stim 5.0 unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines-various transcutaneous electrical stimualton devices.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 118-120 of 127.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines do not support interferential therapy as an isolated intervention. Guidelines will support a one-month trial in conjunction with physical therapy, exercise program and a return to work plan if chronic pain is ineffectively controlled with pain medications or side effects to those medications. Review of the available medical records, fails to document any of the criteria required for an IF Unit one-month trial. As such, this request for a Pro-Stim 5.0 unit is not medically necessary.

**Home exercise kit:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Home Exercise Kits, Updated August 27, 2014.

**Decision rationale:** According to the Official Disability Guidelines the use of a home exercise kit for shoulder home therapy is recommended. Kits include equipment and instruction specifically for shoulder rehabilitation. Considering this, the request for a home exercise kit is medically necessary.