

<b>Case Number:</b>	CM13-0018873		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	05/29/2008
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	08/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/30/2013

### 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 Family Medicine and is licensed to practice in Tennessee, California and Florida. 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 58-year-old male who reported an injury to his left cervical region on 05/29/09. No description of the initial injury was provided in the submitted documentation. The clinical note dated 03/04/13 indicates the injured worker complaining of 7/10 pain. The clinical note dated 04/01/13 indicates the injured worker continuing with complaints of right sided low back and leg pain that was rated as 6/10. The injured worker was also identified as having left shoulder blade pain. There is an indication the injured worker is undergoing exercises; however, these are limited by pain. Upon exam, tenderness was identified at the left parascapular region with hypertonicity. The injured worker stated he was unable to remain seated for any prolonged period of time. The clinical note dated 05/06/14 indicates the injured worker complaining of a tingling sensation in the right lower extremity. Previous epidural injections provided limited relief. The clinical note dated 06/20/13 indicates the injured worker continuing with complaints of multiple areas of pain. The clinical note dated 07/23/13 indicates the injured worker complaining of tenderness upon palpation at the neck and left shoulder. The clinical note dated 07/29/13 indicates the injured worker continuing with low back and left shoulder pain. The utilization review dated 08/14/13 resulted in a denial for a therapeutic ultrasound treatment as no high quality studies support the use of therapeutic ultrasound in the trapezial region.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**THERAPEUTIC ULTRASOUND OF LEFT TRAPEZIUS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
ULTRASOUND Page(s): 123.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS.  
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper  
Back Chapter Ultrasound Therapeutic.

**Decision rationale:** The request for therapeutic ultrasound for the left trapezius is not medically necessary under the Official Disability Guidelines (ODG). The documentation indicates the injured worker complaining of left sided cervical region pain. No high quality studies have been published in peer reviewed literature supporting the safety and efficacy of the use of therapeutic ultrasound to address mechanical neck pain. Without any high quality studies supporting the safety and efficacy of the use of therapeutic ultrasound, this request are not indicated as medically necessary.