

<b>Case Number:</b>	CM13-0051944		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	02/07/2012
<b>Decision Date:</b>	03/12/2014	<b>UR Denial Date:</b>	10/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice 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 physician 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 46-year-old female who reported an injury on 02/07/2012. The patient is currently diagnosed with cervical spine disc syndrome without myelopathy and lumbar spine disc syndrome without myelopathy. The patient was seen by [REDACTED] on 09/06/2013. The patient reported pain in the neck and lower back with radiation to bilateral upper and lower extremities. Physical examination revealed mild spasm in the cervical spine, tenderness to palpation, slightly decreased range of motion, positive compression testing, diminished lumbar range of motion with paraspinous tenderness, 2+ deep tendon reflexes, and intact sensation. Treatment recommendations included a course of 24 sessions of physical therapy, a urinalysis, and an ultrasound stimulator unit for home use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**An ultrasound stimulator:** 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).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Therapeutic Ultrasound Page(s): 123.

**Decision rationale:** California MTUS Guidelines state therapeutic ultrasound is not recommended. There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating patients with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. The medical necessity for the requested unit has not been established. There was no treatment plan including the specific short and long term goals of treatment with the unit provided. As guidelines do not recommend the use of therapeutic ultrasound, the current request is not medically appropriate. Therefore, the request is non-certified.