

Case Number:	CM14-0017533		
Date Assigned:	04/14/2014	Date of Injury:	12/15/2012
Decision Date:	07/24/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/11/2014

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 & Rehabilitation, has a subspecialty in Pain Management 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:

This is a 53-year-old male with a 12/15/2012 date of injury. The specific mechanism of injury was not described. A 1/21/14 medical report identified that the patient was seen for blood pressure check, gastrointestinal and insomnia evaluation. A 2/6/14 medical report identified low back and left leg pain. Nothing change since the previous visit. An exam revealed very limited and painful range of motion, paravertebral muscle spasm was noted, and positive SLR and Lasegue's test on the left. There was some gastrocnemius and anterior tibialis weakness on the left and the patient had dermatomal changes at L5 and S1 levels on the left. A 2/19/14 medical report identified pain, myospasm, and numbness. There was also limited range of motion, pain on palpation, edema, and sensory loss. A 2/3/14 determination for the request was non-certified given no nationally recognized, evidence-based guidelines that recommend the at home use of ultrasound.

IMR ISSUES, DECISIONS AND RATIONALES

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

ULTRASOUND STIMULATOR QTY: 1.00: 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) Low Back Chapter, Ultrasound, therapeutic.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter Ultrasound, therapeutic.

Decision rationale: CA MTUS states that physical modalities such as ultrasound have no proven efficacy in treating acute low back symptoms. In addition, ODG states that there is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. There was no clear indication for utilization of ultrasound. It is also not clear if the patient has the required skills to utilize an ultrasound unit, or who will be providing the therapy, since it appears to be intended for the low back. There was insufficient documentation to support the necessity of this request. Therefore, the request is not medically necessary.

CONDUCTIVE GEL QTY: 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter Ultrasound, therapeutic.

Decision rationale: The ODG states that there is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. Given that the medical necessity for a therapeutic ultrasound unit was not established, there was no indication for the need of conductive gel. The request is not medically necessary.