

Case Number:	CM14-0115954		
Date Assigned:	09/23/2014	Date of Injury:	09/11/2006
Decision Date:	12/12/2014	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	07/23/2014

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 Occupational Medicine 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 52-year-old male with a 9/11/06 date of injury. The mechanism of injury occurred when the patient was moving pallets and some boxes fell on his back. According to a handwritten and largely illegible progress note dated 7/22/14, the patient complained of cervical, thoracic, lumbar pain with myospasms and weakness. He also complained of left shoulder pain with weakness and right knee pain with spasms and weakness. Objective findings: limited cervical spine/lumbar spine/left shoulder range of motion with pain, tenderness to palpation of cervical/thoracic/lumbar/left shoulder/bilateral knees, edema of right knee, sensory loss of bilateral upper and lower extremities. Diagnostic impression: left rotator cuff syndrome, myofascial pain, cervical/thoracic/lumbar sacroiliitis, cervical/thoracic/lumbar degenerative disc disease, cervical and lumbar radiculopathy, bilateral knees internal derangement. Treatment to date: medication management, activity modification, surgeries, TENS unit, physical therapy, chiropractic treatment, shockwave therapy. A UR decision dated 7/7/14 denied the request for ultrasound stimulator. CA MTUS does not recommend therapeutic ultrasound. Furthermore, submitted records indicated the patient already had an at home trial of a TENS unit without a clear home exercise/stretching program in place.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound stimulator: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 123. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter - Therapeutic Ultrasound

Decision rationale: MTUS states that therapeutic ultrasound is not recommended, with little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating pain or a range of musculoskeletal injuries or for promoting soft tissue healing. The effectiveness of ultrasound for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. A specific rationale identifying why this patient would require therapeutic ultrasound despite lack of guideline support was not provided. Therefore, the request for Ultrasound stimulator was not medically necessary.