

<b>Case Number:</b>	CM14-0035860		
<b>Date Assigned:</b>	06/23/2014	<b>Date of Injury:</b>	11/12/2012
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	02/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2014

### 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 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:

The injured worker is a 48-year-old male with a reported date of injury on 11/12/2012. The mechanism of injury reportedly occurred when the injured worker tripped over a low guard rail. The injured worker presented with constant chronic pinching pain in the upper back radiating to the neck. In addition, the injured worker complained of bilateral shoulder pain, left wrist and hand pain, and low back pain. The injured worker presented with negative Spurling's, Adson's, and abduction/extension rotation tests bilaterally. The injured worker presented with paraspinal muscular tenderness to palpation and tenderness to palpation of the spinous process. Motor strength between the C3 and S1 was rated 5/5. Waddell's signs were negative. According to the clinical documentation dated 03/05/2013 the injured worker underwent EMG and NCS which revealed abnormal EMG and NCS of the left upper extremity. Previous physical therapy and conservative care was not provided within the documentation available for review. The injured worker's diagnoses included myofasciitis, stress, anxiety, hypertension, headaches, insomnia, lumbar spine disc syndrome, cervical spine radiculitis, and lumbar spine radiculitis. The injured worker's medication regimen included losartan and benazepril. The Request for Authorization for conductive gel and ultrasound stimulator was submitted on 03/19/2014. The rationale for the request was not provided within the documentation available for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Conductive Gel:** 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 Ultrasound, Therapeutic Page(s): 123.

**Decision rationale:** The California MTUS Guidelines state that therapeutic ultrasound is not recommended. Therapeutic ultrasound is one of the most widely and frequently used electrical physical agents. Despite over 60 years of clinical use, the effectiveness of ultrasound for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or range of musculoskeletal injuries or for promoting soft tissue healing. The clinical information provided for review lacks documentation related to previous physical therapy and conservative care. In addition, the request as submitted failed to provide specific site at which the ultrasound stimulator was to be utilized. The guidelines do not recommend the use of therapeutic ultrasound. Therefore, the request for ultrasound stimulator is non-certified. As the ultrasound stimulator is not certified, the need for conductive gel would not be medically necessary. Therefore, the request for conductive gel is not medically necessary.

**Ultrasound Stimulator:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2004, Initial Care, pages 173-175.

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

**Decision rationale:** The California MTUS Guidelines state that therapeutic ultrasound is not recommended. Therapeutic ultrasound is one of the most widely and frequently used electrical physical agents. Despite over 60 years of clinical use, the effectiveness of ultrasound for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or range of musculoskeletal injuries or for promoting soft tissue healing. The clinical information provided for review lacks documentation related to previous physical therapy and conservative care. In addition, the request as submitted failed to provide specific site at which the ultrasound stimulator is to be utilized. The guidelines do not recommend the use of therapeutic ultrasound. Therefore, the request for ultrasound stimulator is not medically necessary.