

<b>Case Number:</b>	CM14-0061165		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	04/28/2011
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	04/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/02/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 patient is a 41-year-old female who has submitted a claim for myofasciitis; stress/anxiety; headaches; sexual dysfunction; cervical, thoracic, and lumbar spine disc syndrome; pain in the cervical, thoracic and lumbar spine; blurry vision; and dizziness associated with an industrial injury date of April 28, 2011. Medical records from 2011 to 2014 were reviewed and showed that patient complained of persistent cervical and lumbar spine pain and there was associated spasms and numbness noted. Physical examination showed tenderness of the cervical and lumbar spine and range of motion was limited due to pain. Edema or swelling was noted on the cervical spine and decreased sensation on both upper and lower extremities. Trigger points were given on the cervical and lumbar spine. Kemp's and maximum cervical compression test were positive. MRI of the cervical spine, dated February 3, 2014, showed straightening of the cervical spine, early disc desiccation at C2-C3 to C6-C7 levels, mucosal thickening in right maxillary sinus, and exiting nerve roots were unremarkable at all levels. MRI of the lumbar spine, dated February 3, 2014, revealed disc desiccation at L3-L4, L4-L5 and L5-S1; modic type II end-plate degenerative changes at L5-S1; L3-L4 diffuse disc protrusion with effacement of the thecal sac; L4-L5 diffuse disc protrusion with annular tear effacing the thecal sac; L5-S1 focal central disc extrusion with superior migration effacing the thecal sac, neuroforaminal narrowing without impingement of the nerve roots; and grade I anterolisthesis of L5 over S1. Treatment to date has included medications, physiotherapy, trigger point therapy, home exercise program, activity modification, right sacroiliac steroid injection, and extra-corporeal shock-wave treatment. Utilization review, dated April 8, 2014, denied the request for ultrasound stimulator because it is not certifiable for home usage.

### 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 Therapeutic Ultrasound Page(s): 123.

**Decision rationale:** According to page 123 of the CA MTUS Chronic Pain Medical Treatment Guidelines, therapeutic ultrasound is not recommended. 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. In this case, the rationale for the request was not provided by the medical records submitted for review. Furthermore, therapeutic ultrasound is not recommended as stated by the guidelines above. The medical necessity was not established. Moreover, the present request failed to specify the body part to be treated. Therefore, the request for Ultrasound Stimulator is not medically necessary.