

Case Number:	CM15-0181690		
Date Assigned:	09/23/2015	Date of Injury:	01/21/2015
Decision Date:	11/03/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	09/15/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 23 year old male who sustained an industrial injury on 01-21-2015. According to a progress report dated 08-07-2015, the injured worker presented for ultrasound therapy of his lumbar. Low back pain radiated to the lower extremity. Left numbness was noted. Lower extremity weakness kept the injured worker from walking much. He still had "considerable" pain in the nail site described as electric. He was currently not working. Medications included Naproxen, Lidopro, TENS and heating pad. Sleep was "ok". Mood was a little better after the last depression screening visit. He was still going to chiropractic and acupuncture sessions. Objective findings, documented by the provider, included lower extremity strength 5 out of 5. Tightness of the low back was reported with straight leg raise. Reflexes were 2 plus. Lumbar "PSM" was noted. Diagnoses included lumbar sprain strain rule out degenerative disc disease, left buttock pain, left leg pain, left hip and myofascial pain. Ultrasound therapy was provided for the left hip and lumbar. The treatment plan included continuation of home exercise program, TENS, heating pad, medications, acupuncture and chiropractic care. Work status included modified work. He was to return to the clinic in 5 weeks. An authorization request dated 08-07-2015 was submitted for review. The requested services included ultrasound therapy and return to clinic follow up, on 08-24-2015, Utilization Review non-certified the request for retro ultrasound therapy for the left hip and lumbar date of service 08-07-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro: Ultrasound therapy for his left hip/lumbar date of service 8/7/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic Chapter, under Ultrasound.

Decision rationale: The patient presents on 08/07/15 with lower back pain which radiates into the left lower extremity and associated numbness and weakness in the affected limb. The patient's date of injury is 01/21/15. The request is for RETRO ULTRASOUND THERAPY FOR HIS LEFT HIP/LUMBAR DATE OF SERVICE 8/7/2015. The RFA was not provided. Physical examination dated 08/07/15 reveals normal strength in the lower extremities, with tightness in the lower back and lumbar paraspinal musculature noted. The patient is currently prescribed Naproxen and Lidopro. Patient is currently not working. ODG Guidelines, Low Back - Lumbar & Thoracic Chapter, under Ultrasound, therapeutic Section states: Not recommended based on the medical evidence, which shows that there is no proven efficacy in the treatment of acute low back symptoms. In this RCT ultrasound therapy was not efficacious in relieving chronic low back pain. (Licciardone, 2013) There is no high quality evidence to support the use of ultrasound for improving pain or quality of life in patients with non-specific chronic LBP. In regard to the retrospective request for lumbar ultrasound therapy for this patient's chronic lower back pain, such treatments are not supported by guidelines. While this patient presents with significant chronic lower back pain with a radicular component, the use of therapeutic ultrasound therapy for low back pain is not recommended by ODG owing to a lack of clinical trials demonstrating efficacy. Given the lack of guideline support for this procedure, the request cannot be substantiated and IS NOT medically necessary.