

Case Number:	CM15-0183502		
Date Assigned:	09/30/2015	Date of Injury:	02/20/2012
Decision Date:	11/30/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/17/2015

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 29 [REDACTED] year old female, who sustained an industrial injury on 2-20-2012. The injured worker is being treated for lumbar disc displacement with myelopathy, lesion of sciatic nerve and lumbar segmental dysfunction. Treatment to date has included medications, modified work, injections, and acupuncture. Per the Primary Treating Physician's Progress Report dated 7-25-2012 the injured worker reported constant, moderate lumbar spine pain. There is numbness extending to the legs. Objective findings of the lumbar spine included +3 spasm and tenderness of the L2-S1 paraspinal muscles bilaterally and the multifidus and Quadratus lumborum muscles bilaterally. The notes from the provider do not document efficacy of the prescribed treatment. Work status was temporarily totally disabled for the next 6 weeks. The plan of care included functional restoration program and ultrasound stimulator and authorization was requested for ultrasound stimulator, conductive gel or paste and delivery (DOS 8-04-2012). On 9-14-2015, Utilization Review non-certified the request for ultrasound stimulator, conductive gel or paste and delivery (DOS 8-04-2012).

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro ultrasound stimulator, conductive gel or paste and delivery DOS 8/4/12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: The patient was injured on 02/20/12 and presents with lumbar spine pain. The retrospective request is for a Retro ultrasound stimulator, conductive gel or paste and delivery DOS 8/4/12. There is no RFA provided and the patient's work status on 08/04/12 is not provided. 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." The patient is diagnosed with lumbar disc displacement with myelopathy, lesion of sciatic nerve, and lumbar segmental dysfunction. Treatment to date includes medications, modified work, injections, and acupuncture. The report with the request is not provided and the reason for the request is not provided either. In this case, the patient continues with low back pain. In this case, the use of therapeutic Ultrasound Therapy for low back pain is not recommended by ODG guidelines. Given the lack of guideline support, the request is not medically necessary.