

Case Number:	CM14-0138179		
Date Assigned:	09/05/2014	Date of Injury:	01/03/1991
Decision Date:	10/08/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	08/26/2014

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 licensed in Chiropractor, has a subspecialty in Acupuncture and is licensed to practice in Texas. 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 62-year-old male who reported an injury of unknown mechanism on 01/03/1991. On 07/11/2014, his diagnoses included lumbar spondylitis and sciatica. His complaints included low back pain rated 7/10. He had restricted range of motion in the lumbosacral spine, with muscle spasms noted. He also had degenerative disc disease of the lumbar spine. The treatment plan included a home exercise program, use of heat and ice at home, rest and a vasopneumatic device. There was no rationale included in this worker's chart. A Request for Authorization dated 07/25/2014 was included.

IMR ISSUES, DECISIONS AND RATIONALES

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

CMT/Vasopneumatic device (*type of ultrasound) on a prn basis (as needed)-no f&d - lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy/Manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

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

Decision rationale: Per the California MTUS Guidelines, therapeutic ultrasound is not recommended. Therapeutic ultrasound is one of the most widely and frequently used electrophysiological agents. The effectiveness of this mode of treatment remains questionable. There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain, a range of musculoskeletal injuries, or for promoting soft tissue healing. The guidelines do not support this type of device. Therefore, the request for CMT/Vasopneumatic device (*type of ultrasound) on a prn basis (as needed)-no f&d - lumbar spine is not medically necessary and appropriate.