

<b>Case Number:</b>	CM15-0111214		
<b>Date Assigned:</b>	06/17/2015	<b>Date of Injury:</b>	08/11/2014
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	05/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 56 year old male, who sustained an industrial injury on 8/11/2014. The mechanism of injury was not noted. The injured worker was diagnosed as having lumbar sprain/strain and lumbar degenerative disc disease. Treatment to date has included diagnostics, acupuncture, chiropractic, transcutaneous electrical nerve stimulation unit, home exercise program, and medications. Currently, the injured worker complains of low back pain, rated 6/10. His pain was constant except when taking medications. He continued to report mild and intermittent gastritis symptoms. Current medication regime was not noted. Objective findings included mild lumbar spine tenderness. Magnetic resonance imaging of the lumbar spine (9/10/2014) was submitted. His work status remained modified with restrictions and he was not working. The treatment plan included 3 ultrasound therapy sessions for the thoracic and lumbar spines. The rationale for the requested treatment was not noted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultrasound therapy for the lumber & thoracic spine, quantity: 3 sessions: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (updated 05/15/15) Ultrasound, therapeutic.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 300.

**Decision rationale:** The ACOEM chapter on low back complaints states: Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies. Based on the above guidelines per the ACOEM, the request is not medically necessary.