

Case Number:	CM15-0149590		
Date Assigned:	09/04/2015	Date of Injury:	06/28/2004
Decision Date:	11/12/2015	UR Denial Date:	07/21/2015
Priority:	Standard	Application Received:	07/31/2015

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 71 year old male who sustained an industrial injury on 06-28-2004. A review of the medical records indicated that the injured worker is undergoing treatment for cervical discogenic syndrome, bilateral cervical radiculitis, left rotator cuff tear, left De Quervain's tenosynovitis, lumbar discogenic syndrome, lumbar radiculitis and depression. According to the treating physician's progress report on 07-01-2015, the injured worker continues to experience neck pain radiating to the upper back and trapezii without upper extremity numbness or weakness, rated at 4-5 out of 10 on the pain scale, left shoulder pain rated at 5-6 out of 10 and lumbar spine pain rated 4-5 out of 10 with anterior thigh pain and lower extremity paresthesias. Examination of the cervical spine demonstrated tenderness to the left suboccipital and paraspinal areas to the left trapezius, rhomboid and scapular regions with spasm. There was full range of motion with crepitation noted. The left shoulder was tender at the left trapezius, rotator cuff and anterior left shoulder. Range of motion noted extension at 30 degrees, flexion at 140 degrees and abduction at 150 degrees with positive impingement and O'Brien's signs. Drop arm test was negative. The thoracolumbar area was tender at the paraspinal muscles, more on the left side. Bilateral straight leg raise at 35 degrees was noted. Tactile sensation of both legs was normal. Prior treatments have included diagnostic testing, cervical traction, back support brace, transcutaneous electrical nerve stimulation (TEN's) unit, physical therapy, chiropractic rehabilitative program, psychological evaluation and cognitive behavioral therapy (CBT), acupuncture therapy, home exercise program and medications. Current medication was noted as LidoPro cream. Treatment plan consists of pending authorization for

updated cervical spine, left shoulder, lumbar spine magnetic resonance imaging (MRI), continuing medication regimen, home exercise program, transcutaneous electrical nerve stimulation unit, back brace and the current request for ultrasound trial. On 07-21-2015 the Utilization Review determined the request for ultrasound was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal therapy in a patient that has been instructed on a home exercise program for this chronic injury. Ultrasound therapy, high-frequency sound waves, is used to warm superficial soft tissues or with the intention of facilitating tissue healing at the cellular level. Ultrasound heating may be useful for tendon injuries or for short-term pain relief of muscle strain or spasm, but is not recommended over other, simpler heat therapies. Therapeutic ultrasound is one of several rehabilitation interventions used for the management of pain. One meta-analysis concludes that ultrasound therapy was not shown to have a clinically important effect on pain relief for patients. Submitted reports have not adequately demonstrated the indication to support further therapy when prior therapy treatment rendered has not resulted in any functional benefit. The Ultrasound Treatment is not medically necessary and appropriate.