

<b>Case Number:</b>	CM15-0071014		
<b>Date Assigned:</b>	04/21/2015	<b>Date of Injury:</b>	08/01/2011
<b>Decision Date:</b>	05/20/2015	<b>UR Denial Date:</b>	03/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2015

### 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 37 year old female who sustained an industrial injury on August 1, 2011. She has reported injury to the wrists and neck and has been diagnosed with rotator cuff tear status post bilateral surgery, cervical degenerative disc disease without radiculopathy, myofascial pain, shoulder sprain/strain, and carpal tunnel syndrome left wrist. Treatment has included medical imaging, physical therapy, surgery, medications, injections, TENS unit, and a home exercise program. Currently the injured worker complains of increase pain to the neck and sleeping difficulty. The treatment request included a retrospective ultrasound.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective ultrasound:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain Chapter, Ultrasound (therapeutic).

**Decision rationale:** The patient presents with pain in the bilateral wrists and right shoulder. The request is for RETROSPECTIVE ULTRASOUND. Patient is status post left carpal tunnel surgery 05/07/14. Patient's treatments have included cortisone injections, medications, home exercise program, TENS unit, and medications. Per 03/18/15 progress report, patient's diagnosis include rotator cuff (capsule) tear, cervical degenerative disc disease with radiculopathy, myofascial pain, sleep issues, poor coping, shoulder sprain/strain, carpal tunnel syndrome left wrist, and sensory changes of RUE. Patient's medications, per 03/13/15 progress report include Naproxen, Omeprazole, Lunesta, Gabapentin, Lidopro Cream, and Cyclobenzaprine. Patient is permanent and stationary. ODG Guidelines, Pain Chapter, under Ultrasound (therapeutic) states, "Not recommended. Therapeutic ultrasound is one of the most widely and frequently used electrophysical agents. Despite over 60 years of clinical use, the effectiveness of ultrasound for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. (Robertson, 2001)." In progress report dated 01/07/15, it is stated that ultrasound therapy relaxed the patient's muscle and mild symptom relief. ODG Guidelines do not support the use of ultrasound for relaxing muscles or pain. Therefore, the request IS NOT medically necessary.