

<b>Case Number:</b>	CM15-0052633		
<b>Date Assigned:</b>	04/16/2015	<b>Date of Injury:</b>	03/22/2006
<b>Decision Date:</b>	06/08/2015	<b>UR Denial Date:</b>	03/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2015

### 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, Arizona  
 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 58-year-old female who reported an injury on 03/22/2008. The mechanism of injury was not specifically stated. The injured worker is currently diagnosed with obesity, sexual dysfunction, GERD, insomnia, persistent depression, left shoulder status post arthroscopic subacromial decompression and status post lumbar decompression and fusion. The injured worker presented on 02/03/2015 for a follow up evaluation with complaints of persistent low back pain and an inability to function. The injured worker underwent a lumbar spine fusion in 10/2008. The injured worker has not been able to return to work. The current medication regimen includes tramadol, Xanax, Prilosec, Naprosyn, and a compounded cream. Upon examination of the lumbar spine, there was limited range of motion, an extremely stiff gait, tenderness to palpation, trigger points and spasms in the right lumbar area over the hardware, and positive straight leg raising bilaterally. Treatment recommendations included continuation of the current medication regimen, a CT scan of the lumbar spine, electrodiagnostic studies involving the bilateral lower extremities, and an X-Force Solar Care electrical stimulation unit. A request for authorization form was submitted on 02/03/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Massage Therapy (sessions) (Lumbar Spine) QTY: 12: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

**Decision rationale:** The California MTUS Guidelines state massage therapy is recommended as an option as indicated. This treatment should be an adjunct to other recommended treatment to include exercise and should be limited to 4 to 6 visits in most cases. In this case, there is no indication that this injured worker is participating in an active rehabilitation program. The request for 12 sessions of massage therapy exceeds guideline recommendations. Given the above, the request is not medically necessary.

**EMG Right Lower Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state electromyography including H-reflex test may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In this case, there was no objective evidence of neurologic compromise to support the necessity for electrodiagnostic testing. There is also no mention of a recent attempt at any conservative treatment prior to the request for an electrodiagnostic study. The injured worker is currently pending a CT scan of the lumbar spine. Given the above, the medical necessity has not been established. As such, the request is not medically appropriate at this time.

**EMG Left Lower Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state electromyography including H-reflex test may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In this case, there was no objective evidence of neurologic compromise to support the necessity for electrodiagnostic testing. There is also no mention of a recent attempt at any conservative treatment prior to the request for an electrodiagnostic study. The injured worker is currently pending a CT scan of the lumbar spine.

Given the above, the medical necessity has not been established. As such, the request is not medically appropriate at this time.

**NCV Right Lower Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state electromyography including H-reflex test may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In this case, there was no objective evidence of neurologic compromise to support the necessity for electrodiagnostic testing. There is also no mention of a recent attempt at any conservative treatment prior to the request for an electrodiagnostic study. The injured worker is currently pending a CT scan of the lumbar spine. Given the above, the medical necessity has not been established. As such, the request is not medically appropriate at this time.

**NCV Left Lower Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state electromyography including H-reflex test may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In this case, there was no objective evidence of neurologic compromise to support the necessity for electrodiagnostic testing. There is also no mention of a recent attempt at any conservative treatment prior to the request for an electrodiagnostic study. The injured worker is currently pending a CT scan of the lumbar spine. Given the above, the medical necessity has not been established. As such, the request is not medically appropriate at this time.

**X-Force Solar Care Home Use:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, TENS therapy and PENS therapy have no proven efficacy in treating acute low back symptoms. Insufficient evidence exists to determine the effectiveness of sympathetic therapy involving electrical stimulation. Therefore, the current request cannot be determined as medically appropriate in this case. In addition, there is no evidence of a successful 1 month trial prior to the request for a unit purchase. Given the above, the request is not medically necessary.

**Gabapentin, Ketoprofen, Tramadol Topical Cream/compound:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** The California MTUS Guidelines state any compounded product that contains at least one drug that is not recommended, is not recommended as a whole. Gabapentin is not recommended as there is no peer reviewed literature to support its use. The only FDA approved topical NSAID is diclofenac. The request for a compounded cream containing ketoprofen would not be supported. There is also no strength, frequency or quantity listed in the request. As such, the request is not medically appropriate.