

<b>Case Number:</b>	CM13-0040388		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	05/03/2001
<b>Decision Date:</b>	03/14/2014	<b>UR Denial Date:</b>	10/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice and is licensed to practice in California. 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 physician 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 patient is a 53-year-old male who reported an injury on 05/03/2001. The mechanism of injury is not specifically stated. The patient is currently diagnosed with lumbago, long term use of other medication, and status post annuloplasty in 2002. The patient was seen by [REDACTED] on 09/26/2013. The patient reported ongoing lower back pain with numbness and tingling in bilateral lower extremities. Physical examination revealed normal ambulation and no acute distress. Treatment recommendations included continuation of current medication, a lumbar support seat cushion, and a 13 week gym membership.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) lumbar support seat cushion:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Official

Disability Guidelines state lumbar supports are not recommended for prevention, but are recommended as an option for treatment. As per the documentation submitted, there is no evidence of a significant musculoskeletal or neurological deficit upon physical examination on the requesting date of 09/26/2013. There is no documentation of significant instability, spondylolisthesis, or compression fractures. The medical necessity for the requested durable medical equipment has not been established. As such, the request is non-certified.

**Gym membership, 13 week membership:** 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-Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Gym Memberships.

**Decision rationale:** Official Disability Guidelines state gym memberships are not recommend as a medical prescription unless a home exercise program has not been effective and there is a need for equipment. As per the documentation submitted, there is no evidence of a significant musculoskeletal or neurological deficit upon physical examination. There is no indication that a home exercise program has not been effective, nor is there a need for equipment. The medical necessity has not been established. As such, the request is non-certified.

**Prescription of Mirtazapine 15mg, #30 is:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California Chronic Medical Treatment Guidelines (May 2009)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Page(s): 13-16.

**Decision rationale:** California MTUS Guidelines state antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in the use of other analgesic medication, sleep quality and duration, and psychological assessment. As per the documentation submitted, the patient has continuously utilized this medication. However, the patient does not report psychiatric symptoms nor does the patient demonstrate neuropathic pain upon physical examination. The medical necessity for the requested medication has not been established. As such, the request is non-certified.