

<b>Case Number:</b>	CM13-0067603		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	01/13/2006
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	11/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, 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 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/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 injured worker is a 73-year-old female who reported injury on 01/13/2006. The mechanism of injury was cumulative trauma. The diagnoses included cervical discopathy, left shoulder impingement syndrome, lumbar spine discopathy, and left hip degenerative joint disease. The documentation of 09/25/2013 revealed the injured worker had ongoing left shoulder, low back, left hip and neck symptomatology. The injured worker reported the left shoulder and low back were the worst. The injured worker was engaging in home exercises and took pain medications on an as-needed basis. The physical examination revealed decreased range of motion and a positive head compression test related to the cervical spine. The shoulder examination revealed pain and tenderness over the anterior and lateral deltoids. The injured worker had decreased range of motion in the left shoulder along with a positive impingement and Neer sign. The O'Brien's maneuver was positive. There was tenderness to palpation over the paralumbar musculature over the L4 and S1 distribution. There was decreased range of motion in the lumbar spine. There was a positive straight leg raise test bilaterally at 80 degrees. The heel/toe walks were noted to be intact but produced increased back pain particularly with ambulation on the heels. There was tenderness over the anterior groin of the hip joint and the trochanteric bursa. There was decreased range of motion of the hip and thigh on the left. Treatment recommendations included access to pool therapy as in a one (1) year pool and gym membership and glucosamine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**POOL AND GYM MEMBERSHIP; ONE YEAR:** 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).

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

**Decision rationale:** The Official Disability Guidelines do not recommend a gym membership as a medical prescription unless a documented home exercise program with periodic assessment and revision has not been effective and there is a need for equipment. Additionally, gym memberships and swimming pool memberships would not generally be considered medical treatment and are not covered under the Official Disability Guidelines. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for pool and gym membership one (1) year is not medically necessary.

**GLUCOSAMINE 500MG #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN, GLUCOSAMINE(CHONDROITIN SULFATE).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Glucosamine Page(s): 50.

**Decision rationale:** The MTUS Guidelines recommend glucosamine as an option given its low risk in patients with moderate arthritis pain especially in the osteoarthritis. The clinical documentation submitted for review, failed to provide the duration of use for the requested medication. The clinical documentation failed to indicate the injured worker had osteoarthritis. The duration of use could not be established through the supplied documentation. The request as submitted failed to indicate the request for the requested medication. Given the above, the request for glucosamine 500 mg #90 is not medically necessary.

**BIOFREEZE ROLL-ON #1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN, TOPICAL ANALGESICS.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Biofreeze.

**Decision rationale:** The Official Disability Guidelines indicate that Biofreeze cryotherapy gel is recommended for acute pain. The clinical documentation submitted for review, failed to indicate a recent injury or acute pain. The duration of use could not be established through the supplied documentation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Biofreeze roll-on is not medically necessary.