

Case Number:	CM14-0067887		
Date Assigned:	07/11/2014	Date of Injury:	04/16/2004
Decision Date:	08/21/2014	UR Denial Date:	05/07/2014
Priority:	Standard	Application Received:	05/12/2014

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, has a subspecialty in Interventional Spine 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:

This patient is a 58-year-old female with date of injury of 04/16/2004. Per treating physician's report 04/29/2014, patient presents with chronic low back and leg pain with an MRI showing disk herniation at L4-L5, electrodiagnostic study showing chronic left L5 radiculopathy. Patient underwent series of lumbar epidural steroid injections, facet injections, and finally underwent percutaneous disk decompression in 2005 and was able to return to work in 2006 without restriction. She worked until 2008 and was taken off of work in April 2008, undergoing additional injection treatments with MRI 2008 showing recurrent L4-L5 disk protrusion with facet arthropathies. She then underwent artificial disk replacement in August 2010. She then developed worsening knee pain and left knee total replacement surgery, currently undergoing postoperative physical therapy. Patient continues to have chronic low back pain and bilateral knee pain and is almost done with physical therapy. The orthopedist has recommended gym membership so that the patient could use the machines to safely strengthen her legs and knees and do the exercises learned at physical therapy. The treating physician makes the argument that the use of the resistance machines at physical therapy was quite helpful and is unable to perform home exercises as she is limited at home and still continues to have pain in the knees. Patient has completed 24 sessions postoperative therapy, but the patient needs to continue to exercise, working on the strength of her lower extremity muscles, and the use of the machines at the gym would help strengthen the knees safely.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trial Health Club Membership For 13 Weeks: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG guidelines have the following regarding exercises: Recommended. There is strong evidence that exercise reduces disability duration in employees with low back pain. In acute back pain, exercise therapy may be effective, whereas in sub-acute back pain, exercises with a graded activity program, and in chronic back pain, intensive exercising should be recommended. Exercise programs aimed at improving general endurance (aerobic fitness) and muscular strength (especially of the back and abdomen) have been shown to benefit patients with acute low back problems. So far, it appears that the key to success in the treatment of LBP is physical activity in any form, rather than through any specific activity. One of the problems with exercise, however, is that it is seldom defined in various research studies and its efficacy is seldom reported in any change in status, other than subjective complaints. If exercise is prescribed a therapeutic tool, some documentation of progress should be expected. While a home exercise program is of course recommended, more elaborate personal care where outcomes are not monitored by a health professional, such as gym memberships or advanced home exercise equipment may not be covered under this guideline, although temporary transitional exercise programs may be appropriate for patients who need more supervision. (van Tulder-Cochrane, 2000) (van Tulder, 2000) (McLain, 1999) (Philadelphia Panel, 2001) (Mannion, 2001) (Burns, 2001) (Linton, 2001) (Pengel, 2002) (Schonstein, 2003) (Storheim, 2003) (Keller, 2004) (Staal, 2004) (Tveito, 2004) (Kool, 2004) (Liddle, 2004) (Oleske, 2004) (Rainville, 2004) (van Poppel, 2004) (Maher, 2004) (Koes, 2004) (Hurwitz, 2005) (Bruce, 2005) (Wright, 2005) (Mayer, 2005) A recent meta-analysis concluded that exercise therapy which consists of individually designed programs, including stretching and strengthening, and delivered with supervision, improves pain and function in chronic nonspecific low back pain. The study found improved pain scores for individually designed programs (5.4 points), supervised home exercise (6.1 points), group (4.8 points), and individually supervised programs (5.9 points) compared with home exercises only. High-dose exercise programs fared better than low-dose exercise programs (1.8 points). Interventions that included additional conservative care were better (5.1 points). A model including these most effective intervention characteristics would be expected to demonstrate important improvement in pain (18.1 points compared with no treatment and 13.0 points compared with other conservative treatment) and small improvement in function (5.5 points compared with no treatment and 2.7 points compared with other conservative treatment). (Hayden, 2005) (Hayden2, 2005) One recent trial found that the best exercise program required that patients continue therapeutic activities even if their pain increased, as opposed to stopping activities due to pain, which supports the hypothesis that fear of pain may be more disabling than pain itself. When pain intensity is used to determine the intensity of the exercises, it may lead to restrictive recommendations regarding activity and work, and it seems to increase behaviors such as taking pain-killers, seeking health care, stopping work, limping, guarding, and talking about pain. (Kool, 2005) After back surgery, there is strong evidence for intensive exercise programs for functional status and faster return to work and there is no evidence they increase the re-operation rate. (Ostelo-Cochrane, 2002) Multiple studies have shown that patients with a high level of fear-avoidance do much better in a supervised exercise program, and patients with low fear-avoidance do better following a self-directed exercise program. When using the Fear-Avoidance Beliefs Questionnaire (FABQ), scores greater than 34 predicted success with supervised exercise. (Fritz, 2001) (Fritz, 2002).

Decision rationale: This patient presents with chronic low back pain with artificial disk replacements in 2010 and a recent knee replacement in December 2013. Patient has completed 24 sessions postoperative physical therapy and still continues to experience pain, weakness. The current request is for trial of health club membership for 13 weeks. The patient desires to go to a gym at least 3 times a week to continue exercises. In his letter, the treating physician makes the argument that the patient needs specialized equipment, namely resistance exercise equipment to strengthen the patient's legs. He makes the argument that he will be providing monitoring of the patient's progress, and he would like to try it for 13 weeks, and if the patient makes good progress, then additional gym membership would be warranted. He provides a clearer goal and indicates that half of the clubs can be quite cost effective as it costs less than \$100 a month. Regarding gym memberships, ODG guidelines support it if there is need for a specific equipment, home exercise program has been ineffective and there is a need for equipment, and if the treatments can be monitored and administered by medical professionals. In this case, patient had knee replacement, requires use of resistance exercise machines, the treating physician will provide monitoring, and the request is quite reasonable in that 13-week trial period is being requested. The current request appears quite consistent with ODG guidelines discussions, and is found to be medically necessary.