

<b>Case Number:</b>	CM15-0100978		
<b>Date Assigned:</b>	06/03/2015	<b>Date of Injury:</b>	04/06/2009
<b>Decision Date:</b>	07/10/2015	<b>UR Denial Date:</b>	04/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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 an 82 year old male, who sustained an industrial injury on 03/20/2010. He has reported injury to the low back. The diagnoses have included lumbar disc disease; lumbosacral neuritis; and disorder of the coccyx. Treatment to date has included medications, diagnostics, bracing, physical therapy, and home exercise program. Medications have included Norco, Gabapentin, and Motrin. A progress note from the treating physician, dated 04/22/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of constant lower back pain; the pain is rated at an 8 on the pain scale; and pain radiates to the bilateral legs, with weakness, numbness, and tingling. Objective findings have included a slow, guarded gait; bilaterally positive straight leg raising test; and limited lumbar range of motion with pain. The treatment plan has included the request for twelve (12) acupuncture visits; three (3) month gym membership with access to pool; three (3) months of scooter chair; and one (1) prescription for Norco 10/325mg #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Twelve (12) acupuncture visits: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.1. Acupuncture Medical Treatment Guidelines Page(s): 13.

**Decision rationale:** The patient presents on 04/22/15 with lower back pain rated 8/10 which radiates into the bilateral legs, and associated weakness, numbness, and tingling in both lower extremities. The patient's date of injury is 03/20/10. Patient has no documented surgical history directed at this complaint. The request is for TWELVE (12) ACUPUNCTURE VISITS. The RFA is dated 04/22/15. Physical examination dated 04/22/15 reveals limited lumbar range of motion secondary to pain, a slow guarded gait, and positive straight leg raise test bilaterally. No other physical findings are included. The patient's current medication regimen is not provided. Diagnostic imaging included lumbar X-ray dated 07/16/14, significant findings include: "Grade I anterolisthesis of L4 over L5 with moderate to severe facet hypertrophy and disc space narrowing at L4-L5 level... There is severe facet hypertrophy at the L5-S1 level with moderate disc space narrowing at the L5-S1 level. Recommend an MRI of the lumbar spine for further evaluation." Patient's current work status is not provided. Chronic Pain Medical Treatment Guidelines, page 13 for acupuncture states: "See Section 9792.24.1 of the California Code of Regulations, Title 8, under the Special Topics section." This section addresses the use of acupuncture for chronic pain in the workers' compensation system in California. The MTUS/Acupuncture Medical Treatment Guidelines (Effective 7/18/09) state that there should be some evidence of functional improvement within the first 3-6 treatments. The guidelines state if there is functional improvement, then the treatment can be extended. In regard to the request for 12 sessions of acupuncture for this patient's chronic lower back pain, the requesting provider has exceeded guideline recommendations. There is no evidence that this patient has had any acupuncture to date. MTUS guidelines specify 3 to 6 treatments initially, with additional acupuncture contingent on improvements; in this case the treater requests 12 initial sessions without first establishing efficacy. Were the request for 3-6 treatments, the recommendation would be for approval. However, such an excessive number of sessions without documented efficacy or functional improvement cannot be substantiated. Therefore, the request IS NOT medically necessary.

**Three (3) month gym membership with access to pool:** 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): Gym memberships.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, Gym memberships.

**Decision rationale:** The patient presents on 04/22/15 with lower back pain rated 8/10 which radiates into the bilateral legs, and associated weakness, numbness, and tingling in both lower extremities. The patient's date of injury is 03/20/10. Patient has no documented surgical history

directed at this complaint. The request is for THREE (3) MONTH GYM MEMBERSHIP WITH ACCESS TO POOL. The RFA is dated 04/22/15. Physical examination dated 04/22/15 reveals limited lumbar range of motion secondary to pain, a slow guarded gait, and positive straight leg raise test bilaterally. No other physical findings are included. The patient's current medication regimen is not provided. Diagnostic imaging included lumbar X-ray dated 07/16/14, significant findings include: "Grade I anterolisthesis of L4 over L5 with moderate to severe facet hypertrophy and disc space narrowing at L4-L5 level. There is severe facet hypertrophy at the L5-S1 level with moderate disc space narrowing at the L5-S1 level. Recommend an MRI of the lumbar spine for further evaluation." Patient's current work status is not provided. ODG guidelines, under Gym Memberships, Low Back, state: "Not recommended 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. Plus, treatment needs to be monitored and administered by medical professionals. While an individual 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. With unsupervised programs there is no information flow back to the provider, so he or she can make changes in the prescription, and there may be risk of further injury to the patient. Gym memberships, health clubs, swimming pools, athletic clubs, etc., would not generally be considered medical treatment, and are therefore not covered under these guidelines." In regard to the request for 3 months of gym membership, such unsupervised memberships are not considered an appropriate medical intervention. Progress note date 04/22/15 requests a 3 month membership at a local gym, though fails to specify a specific reason for the request. ODG guidelines do not support gym memberships as a medical treatment as there is no professional medical oversight to establish goals and monitor progression. Additionally, there is no documentation as to the failure of home-based/self-directed exercise programs to produce results. Therefore, the request IS NOT medically necessary.

**Three (3) months of scooter chair:** 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), Pain (Chronic): Power mobility devices (PMDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

**Decision rationale:** The patient presents on 04/22/15 with lower back pain rated 8/10 which radiates into the bilateral legs, and associated weakness, numbness, and tingling in both lower extremities. The patient's date of injury is 03/20/10. Patient has no documented surgical history directed at this complaint. The request is for THREE (3) MONTHS OF ELECTRIC SCOOTER CHAIR. The RFA is dated 04/22/15. Physical examination dated 04/22/15 reveals limited lumbar range of motion secondary to pain, a slow guarded gait, and positive straight leg raise test bilaterally. No other physical findings are included. The patient's current medication regimen is not provided. Diagnostic imaging included lumbar X-ray dated 07/16/14, significant findings include: "Grade I anterolisthesis of L4 over L5 with moderate to severe facet hypertrophy and

disc space narrowing at L4-L5 level... There is severe facet hypertrophy at the L5-S1 level with moderate disc space narrowing at the L5-S1 level. Recommend an MRI of the lumbar spine for further evaluation." Patient's current work status is not provided. MTUS Chronic Pain Medical Treatment Guidelines, page 99, under 'Power mobility devices (PMDs)' states "Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." In regard to the request for an electric power wheelchair, the treater has not provided a reason for the request. Progress note dated 04/22/15 requests "scooter chair for long distances, rental 3 months." The same progress note includes subjective complaints of weakness in the lower extremities, however no physical findings of significant neurological deficit or loss of motor strength in the upper or lower extremities is provided. There is no discussion of a lack of caregiver assistance, either. MTUS does not support the issuance of motorized wheelchairs in patients with sufficient upper/lower extremity function to propel a standard wheelchair. Without demonstrated upper/lower extremity deficit or discussion as to why this patient does not receive caregiver assistance, the requested motorized wheelchair cannot be substantiated. The request IS NOT medically necessary.

**One (1) prescription for Norco 10/325mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen (Norco); Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** The patient presents on 04/22/15 with lower back pain rated 8/10 which radiates into the bilateral legs, and associated weakness, numbness, and tingling in both lower extremities. The patient's date of injury is 03/20/10. Patient has no documented surgical history directed at this complaint. The request is for ONE (1) PRESCRIPTION OF NORCO 10/325MG #90. The RFA is dated 04/22/15. Physical examination dated 04/22/15 reveals limited lumbar range of motion secondary to pain, a slow guarded gait, and positive straight leg raise test bilaterally. No other physical findings are included. The patient's current medication regimen is not provided. Diagnostic imaging included lumbar X-ray dated 07/16/14, significant findings include: "Grade I anterolisthesis of L4 over L5 with moderate to severe facet hypertrophy and disc space narrowing at L4-L5 level. There is severe facet hypertrophy at the L5-S1 level with moderate disc space narrowing at the L5-S1 level. Recommend an MRI of the lumbar spine for further evaluation." Patient's current work status is not provided. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In regard to the request for Norco, the treater has not provided adequate documentation to

continue its use. This patient has been prescribed Norco since at least 01/08/14. Progress note dated 04/22/15 does not address medication efficacy or provide any functional improvements. There is no discussion of consistent urine drug screening or a stated lack of aberrant behavior, and no urine drug screen toxicology reports were made available for review. MTUS guidelines require documentation of analgesia via a validated scale, activity-specific functional improvements, consistent urine drug screening, and a stated lack of aberrant behavior. No such documentation is provided, therefore the continuation of Norco cannot be substantiated. Owing to a lack of 4A's documentation as required by MTUS, the request IS NOT medically necessary.