

<b>Case Number:</b>	CM15-0205909		
<b>Date Assigned:</b>	10/22/2015	<b>Date of Injury:</b>	09/10/2014
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	09/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2015

### 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: New York, Tennessee

Certification(s)/Specialty: Emergency Medicine

### 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 36 year old male, who sustained an industrial injury on 9-10-2014. The injured worker is undergoing treatment for: thoracic or lumbosacral neuritis or radiculitis, backache, lumbar disc displacement without myelopathy. On 8-11-15 and 8-25-15, he reported low back pain with radiation into the right knee and calf, rated 8-9 out of 10. He also reported pain exacerbation with the functional restoration program. Physical examination revealed restricted lumbar range of motion, tenderness in the low back, positive straight leg raise testing on the right, tenderness over the sacroiliac spine, decreased strength in the hips, and lower extremities, decreased sensation in the right lower extremity. He indicated he has a treadmill at home for exercise and walks without his cane for 20-30 minutes at a time. On 8-28-15, he is reported as having completed 5 weeks of functional restoration program. There is no discussion of failed attempt(s) to return to work. The treatment and diagnostic testing to date has included: at least 5 weeks of functional restoration program, medications, cognitive behavioral therapy, acupuncture, TENS, home exercise program, lumbar epidural injection (4-10-15). Medications have included: terocin patches, eszopiclone, ibuprofen, tramadol. Current work status: temporarily totally disabled as his work restrictions are noted to be un-accommodated. The request for authorization is for: health club membership for 3 months, and functional capacity evaluation. The UR dated 9-23-2015: non-certified the request for health club membership for 3 months, and functional capacity evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

### **Health club membership x 3 months: 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 Chapter, Gym memberships.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Exercise.

**Decision rationale:** Exercise is recommended. There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. Such programs should emphasize education, independence, and the importance of an on-going exercise regime. A recent study of the long term impact of aerobic exercise on musculoskeletal pain found that exercise was associated with a substantial and significant reduction in pain even after adjusting for gender, baseline BMI and attrition, and despite the fact that fractures, a significant predictor of pain, were slightly more common among exercisers. A recent trial concluded that active physical treatment, cognitive-behavioral treatment, and the two combined each resulted in equally significant improvement, much better compared to no treatment. Progressive walking, simple strength training, and stretching improved functional status, key symptoms, and self-efficacy in patients with fibromyalgia. Physical conditioning in chronic pain patients can have immediate and long-term benefits. 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 low back pain 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. In this case there is no documentation that there will be health professional oversight while using the health membership. The request should not be authorized.

### **Functional capacity evaluation x 1: 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), Fitness for Duty Chapter, Functional capacity evaluation (FCE) chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty: Functional Capacity Evaluations.

**Decision rationale:** Both job-specific and comprehensive FCEs can be valuable tools in clinical decision-making for the injured worker; however, FCE is an extremely complex and multifaceted process. Little is known about the reliability and validity of these tests and more research is needed. Guidelines for performing an FCE: If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if 1. Case management is hampered by complex issues such as: Prior unsuccessful RTW attempts. Conflicting medical reporting on precautions and/or fitness for modified job. Injuries that require detailed exploration of a worker's abilities. 2. Timing is appropriate: Close or at MMI/all key medical reports secured. Additional/secondary conditions clarified. Do not proceed with an FCE if: The sole purpose is to determine a worker's effort or compliance. The worker has returned to work and an ergonomic assessment has not been arranged. In this case, the patient is close to MMI. However, there is no documentation of multiple failed attempts at return to work. There is one failed attempt prior to completion of FRP. Criteria for FCE have not been met. The request should not be authorized.