

<b>Case Number:</b>	CM15-0020480		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	03/15/1996
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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 66 year old male, who sustained an industrial injury on 03/15/1996. The diagnoses have included lumbar myoligamentous injury with bilateral lower extremity radicular symptoms, right knee internal derangement status post arthroscopic surgery with eventual right total knee replacement on 05/18/2011, status post crush injury pelvis, and medication induced gastritis. Noted treatments to date have included lumbar epidural steroid injection, trigger point injections, aqua therapy, and medications. Diagnostics to date have included lumbar spine MRI on 09/03/2013 which revealed moderate facet arthropathy with bilateral neural foraminal stenosis at L5-S1, a 3mm disc bulge with associated facet arthropathy and moderate central stenosis and moderate bilateral neural foraminal stenosis at L4-5, a 2mm disc bulge with associated facet arthropathy and moderate bilateral neural foraminal stenosis at L3-4, and a 4mm disc bulge with associated facet arthropathy with moderate to severe right and moderate left neural foraminal stenosis with impingement of the nerve roots L2 and L3 at L2-3. In a progress note dated 12/15/2014, the injured worker presented with complaints of ongoing pain in his lower back which radiates down to the bilateral anterior thighs and lower extremities. The treating physician reported the injured worker requires an ongoing physical maintenance program that can be best done through a gym membership since it allows the injured worker to perform the exercise program as often as it is needed. The physician also stated that the injured worker is to continue to use Norco sparingly, which is evident since his last prescription refill was on October 14, 2014. Utilization Review determination on 01/11/2015 non-certified the request for 1 Year Gym Membership with access to a warm pool and Prilosec 20mg #60 and

modified the request for Norco 10/325mg #60 to Norco 10/325mg #30 citing Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**1 year gym membership with access to a warm 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)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 46-47.

**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 health professional oversight of the exercise program. The request should not be authorized.

**1 prescription of Norco 10/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen; Weaning of Medications.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 11, 74-96.

**Decision rationale:** Norco is the compounded medication containing hydrocodone and acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDS have failed. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case the patient has been using Norco since at least October 2012 . This short-acting medication is being used once daily for pain intensity of 5 or less. The duration of action for Norco is 4 to 6 hours indicating that the patient's pain of low to moderate intensity is adequately controlled without opioids at least 75% of the time. Trial without opioids is indicated. The request should not be authorized.

**1 prescription of Prilosec 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors (PPIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 68.

**Decision rationale:** Prilosec is omeprazole, a proton pump inhibitor (PPI). PPI's are used in the treatment of peptic ulcer disease and may be prescribed in patients who are using non-steroidal anti-inflammatory drugs and are at high risk for gastrointestinal events. Risk factors for high-risk events are age greater than 65, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). In this case the patient's NSAID medication was discontinued. In addition he did not have any of the risk factors for a gastrointestinal event. The request should not be authorized.