

Case Number:	CM14-0080018		
Date Assigned:	07/18/2014	Date of Injury:	10/01/2011
Decision Date:	11/06/2014	UR Denial Date:	05/08/2014
Priority:	Standard	Application Received:	05/30/2014

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 & 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:

The patient is a 36-year-old female with date of injury of 10/01/2011. The listed diagnoses per [REDACTED] from 02/17/2014 are: 1. Primary localized osteoarthritis of the hand. 2. Lumbar disk displacement. 3. Primary localized osteoarthritis of the shoulder region. According to this report, the patient complains shoulder, neck, and back pain. The patient continues to have pain overlying the subacromial area worse when performing activities overhead. She also reports clicking in the shoulder and takes Motrin for the pain with occasional Lortab if the pain is severe. Examination of the patient left shoulder shows no muscle asymmetry, no scapular winging. Range of motion is full. Positive impingement sign and Hawkins' sign. Full range of motion in the neck. Paraspinal spasm on vertebral spine was noted. Straight leg raise is positive at 45 degrees bilaterally. Motor exam is normal bilaterally. Sensory exam is normal. Positive tenderness in the distal radius of the left wrist. Range of motion is limited in the left wrist. Sensation is intact to light touch in all fingers. The utilization review denied the request on 05/08/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gym Membership for lumbar spine, left wrist and shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 83.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) under Low Back Chapter on Gym Memberships

Decision rationale: This patient presents with shoulder, neck, and back pain. The treater is requesting a gym membership for the lumbar spine, left wrist, and shoulder. The MTUS Guidelines recommend exercise, but states that there is no sufficient evidence to support the recommendation of any particular exercise regimen over any exercise regimen. ODG Guidelines do not recommend gym memberships as medical treatments. They are not recommended as a prescription unless a documented home exercise program with periodic assessment and revisions have not been effective; there is a need for equipment; and treatment needs to be monitored administered by medical professionals. The report making the request is missing to determine the rationale behind the request. The treater does not explain what specific equipment is medically essential to help the patient accomplish his exercise routine. There are also no discussions as to how the patient's exercises will be monitored. The request is not medically necessary.