

<b>Case Number:</b>	CM15-0064128		
<b>Date Assigned:</b>	04/10/2015	<b>Date of Injury:</b>	02/09/1983
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	03/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2015

### 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: California

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 68 year old male who sustained an industrial injury on 02/09/1983. Diagnoses include failed back surgery syndrome, right L4 radiculopathy with right lower limb weakness, central L4-L5 focal disc protrusion measuring 4mm causing mild to moderated stenosis, central L3-4 protrusion, central L2-L3 disc protrusion with annular disc tear, lumbar facet joint arthropathy bilaterally L4-L5 facet joints, lumbar post laminectomy syndrome, lumbar degenerative disc disease, right knee derangement, right knee irregular sclerosis in the distal femur and joint space narrowing, right knee osteophytes projection from the tibial spine and medial tibial plateau, and right knee osseous protuberance. Treatment to date has included surgery, diagnostic studies, medications, acupuncture, and gym membership. A physician progress note dated 04/09/2015 documents the injured worker has chronic lumbar spine and bilateral low back pain radiating into his lower extremities right side greater than left. Lumbar and right knee ranges of motion were restricted by pain in all directions. Lumbar discogenic and right knee provocative maneuvers were positive. Nerve root tension signs were negative bilaterally. Muscle stretch reflexes were symmetric bilaterally in all limbs. Muscle strength is 5/5 in all limbs, except for 5-/5 in the right quadriceps. Treatment requested is for Oxycodone 15 mg, ninety count, twelve month gym membership, and Valium 10 mg, thirty count.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Valium 10 mg, thirty count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The requested Valium 10 mg, thirty count, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Benzodiazepines, Page 24, note that benzodiazepines are "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence." The injured worker has chronic lumbar spine and bilateral low back pain radiating into his lower extremities right side greater than left. The treating physician has documented lumbar and right knee ranges of motion were restricted by pain in all directions. Lumbar discogenic and right knee provocative maneuvers were positive. Nerve root tension signs were negative bilaterally. Muscle stretch reflexes were symmetric bilaterally in all limbs. Muscle strength is 5/5 in all limbs, except for 5-/5 in the right quadriceps. The treating physician has not documented the medical indication for continued use of this benzodiazepine medication, nor objective evidence of derived functional benefit from its previous use. The criteria noted above not having been met, Valium 10 mg, thirty count is not medically necessary.

**Oxycodone 15 mg, ninety count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 90.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 Page(s): 78-82.

**Decision rationale:** The requested Oxycodone 15 mg, ninety count, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has chronic lumbar spine and bilateral low back pain radiating into his lower extremities right side greater than left. The treating physician has documented lumbar and right knee ranges of motion were restricted by pain in all directions. Lumbar discogenic and right knee provocative maneuvers were positive. Nerve root tension signs were negative bilaterally. Muscle stretch reflexes were symmetric bilaterally in all limbs. Muscle strength is 5/5 in all limbs, except for 5-/5 in the right quadriceps. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain

contract or urine drug screening. The criteria noted above not having been met, Oxycodone 15 mg, ninety count is not medically necessary.

**Twelve month gym membership:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain, Suffering, And the Restoration of Function Chapter (ACOEM Practice Guidelines, 2nd Edition (2004) Chapter 6), page 114.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise, Pages 46-47 Page(s): 46-47. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Gym Memberships.

**Decision rationale:** The requested Twelve month gym membership is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Exercise, Pages 46-47, note that 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 insufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen." Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic), Gym Memberships, note that gym memberships are "not recommended as a medical prescription unless a home exercise program 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." The injured worker has chronic lumbar spine and bilateral low back pain radiating into his lower extremities right side greater than left. The treating physician has documented lumbar and right knee ranges of motion were restricted by pain in all directions. Lumbar discogenic and right knee provocative maneuvers were positive. Nerve root tension signs were negative bilaterally. Muscle stretch reflexes were symmetric bilaterally in all limbs. Muscle strength is 5/5 in all limbs, except for 5-/5 in the right quadriceps. The treating physician has not documented failed home exercise or specific equipment needs that support the medical necessity for a gym membership. The treating physician has not documented monitored attendance or objective evidence of derived functional benefit from completed gym usage, such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention. The criteria noted above not having been met. Twelve month gym membership is not medically necessary.