

Case Number:	CM13-0038953		
Date Assigned:	01/15/2014	Date of Injury:	03/27/2009
Decision Date:	04/01/2014	UR Denial Date:	09/20/2013
Priority:	Standard	Application Received:	10/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation 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 physician 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 41-year-old male who had a work related injury on 3/27/2009. At the time of injury the patient was digging ditch using a pick. The pick hit a rock and he felt a sudden pain in his lumbar spine. The pain was severe enough that he could no longer stand up straight at the time. The patient was taken to a [REDACTED] where MRIs were taken and confirmed a lumbar spine injury. In May 2009 the patient reported that he developed swelling in the right lower extremity. Ultrasound of the lower extremity was performed and he was told he had phlebitis with a blood clot. The patient was casted for a period of time on the right lower extremity and developed DVT that required treatment with Coumadin. The patient was placed on anticoagulants which continued for six months. He was provided with medications and epidural injections. He has had no recurrence of lower extremity difficulties. Persistent lumbar spine pain has continued along with a right radicular component down to the toes. The patient developed complaints of sleep maintenance insomnia. An MRI in March 2010 showed broad-based subligamentous disc protrusion at L5-S1 and L4-5. In May of 2012 he completed the 6-week program at NCFRP. In a reported dated 10/04/2013 it was noted that the patient currently complains of pain in his low back, which is worse on the right side with pain, numbness, and tingling radiating down the posterolateral portion of the right lower extremity. This pain also radiates to the sole of the foot and to the dorsum of the foot. He used crutches for ambulation and feels he has weakness in his extremities. It is noted that with the use of standard crutches he has developed swelling in the right axilla. This was bad enough that the patient has re-fabricated his current crutches as best he was able to act as a Canadian crutch. Current medication include: Lidoderm 5% patch, Buprenorphine tablet sublingual 2mg, Gabapentin tablets 600mg, Hydrochlorothiazide 25 mg tablet, Chlorthalidone 25 mg tablet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Crutches: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Chapter, Online Edition.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC-Knee & Leg (Acute & Chronic) (updated 01/20/14) and eHow.com.

Decision rationale: CA-MTUS is mute about Canadian Crutches. According to ODG-TWC, Walking aids (canes, crutches, braces, orthoses and walkers) are recommended under certain circumstance. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Non use is associated with less need, negative outcome, and negative evaluation of the walking aid. (Van der Esch, 2003) There is evidence that a brace has additional beneficial effect for knee osteoarthritis compared with medical treatment alone, a laterally wedged insole (orthosis) decreases NSAID intake compared with a neutral insole, patient compliance is better in the laterally wedged insole compared with a neutral insole, and a strapped insole has more adverse effects than a lateral wedge insole. (Brouwer-Cochrane, 2005) Contralateral cane placement is the most efficacious for persons with knee osteoarthritis. With respect to the request for Canadian Crutches it appears the previous UR physician misunderstood the patient when he indicated he would rather use a Walker than crutches which the patient stated was uncomfortable to use. Like canes and walkers, crutches help persons who have limited mobility get around. Individuals with broken legs or muscular or neurological problems often rely on crutches for day-to-day activities. Unlike canes and walkers, which are used singly, crutches come in pairs, with one crutch for each side of the body. There are two main types of crutches: axillary and nonaxillary. Axillary crutches provide support under the armpits, or axilla. Nonaxillary crutches, also known as forearm crutches, made of lightweight aluminum, where Canadian crutches have a cuff that fits around the lower arm, just below the elbow. Many users add padding to the inside of the cuff for additional comfort. Users grasp a hand bar that extends from the crutch. Like the cuff, the hand bar is often padded. Canadian crutches or Lofstrand crutches, provide support around the forearm. Therefore the request for Canadian Crutches is medically necessary.