

Case Number:	CM15-0001088		
Date Assigned:	01/12/2015	Date of Injury:	02/14/2007
Decision Date:	03/06/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/05/2015

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 Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 35 year old male, who sustained an industrial injury on 2/14/2007, after a fall. He has reported injury to the left upper extremity and was diagnosed with non-displaced radial head fracture. The diagnoses have included chronic left upper extremity pain due to complex regional pain syndrome, neuropathy, and acid reflux problems. Treatment to date has included conservative measures. Currently, the injured worker reported pain along the left side of his neck and entire left upper extremity. He completed 4/6 approved acupuncture visits and stated that it has helped with pain, but did not attend the last two sessions. He admitted to worsening depression and did not feel motivated to answer phone calls or attend follow-up visits. Daily thoughts of suicide, without a plan, were reported. He denied balance problems. Physical exam did not note swelling in any extremities. Tenderness to palpation and atrophy was present to the left upper extremity. Psychiatric treatment was documented as authorized but was not attended. The injured worker reported that his single point cane was stolen and he felt unstable while walking and an antalgic gait was documented. Normal muscle tone, without atrophy, was noted to bilateral lower extremities. Current medications included Lidoderm 5% (3 patches) on 12hrs daily, off 12 hrs daily, Protonix 20mg twice daily, and Gabapentin 300mg twice daily. On 12/24/2014, Utilization Review (UR) non-certified a request for prescription for Lidoderm 5% #90, with 1 refill, noting lack of compliance with MTUS recommendations. The UR non-certified a request for 1 single point cane, noting lack of compliance with Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% #90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56.

Decision rationale: According to MTUS guidelines, Lidoderm is the brand name for a lidocaine patch produced by [REDACTED]. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin). In this case, there is no documentation that the patient developed neuropathic pain that did not respond to first line therapy and the need for Lidoderm patch is unclear. There is no documentation of efficacy of previous use of Lidoderm patch.

1 single point cane: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Walking aids (canes, crutches, braces, orthoses, & walkers)

Decision rationale: According to ODG guidelines, walking aids including single point cane Recommended, as indicated below. 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. Nonuse 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. In fact, no cane use may be preferable to ipsilateral cane usage as the latter resulted in the highest knee moments of force, a situation which may exacerbate pain and deformity. (Chan, 2005) While recommended for therapeutic use, braces are not necessarily recommended for prevention of injury. (Yang, 2005) Bracing after anterior cruciate ligament reconstruction is expensive and is not proven to prevent injuries or influence outcomes. (McDevitt, 2004) Recommended, as indicated below. Assistive devices for ambulation can reduce pain associated with OA. Frames or wheeled walkers are preferable for patients with bilateral disease. (Zhang, 2008) While foot orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when

added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) In patients with OA, the use of a cane or walking stick in the hand contralateral to the symptomatic knee reduces the peak knee adduction moment by 10%. Patients must be careful not to use their cane in the hand on the same side as the symptomatic leg, as this technique can actually increase the knee adduction moment. Using a cane in the hand contralateral to the symptomatic knee might shift the body's center of mass towards the affected limb, thereby reducing the medially directed ground reaction force, in a similar way as that achieved with the lateral trunk lean strategy described above. Cane use, in conjunction with a slow walking speed, lowers the ground reaction force, and decreases the biomechanical load experienced by the lower limb. The use of a cane and walking slowly could be simple and effective intervention strategies for patients with OA. In a similar manner to which cane use unloads the limb, weight loss also decreases load in the limb to a certain extent and should be considered as a long-term strategy, especially for overweight individuals. (Reeves, 2011) See also U-Step walker. There is no documentation for the need of single point cane or a walking aid. There is no evidence of osteoarthritis or a knee damage that may benefit from a cane.