

Case Number:	CM15-0197927		
Date Assigned:	10/13/2015	Date of Injury:	09/04/1999
Decision Date:	11/25/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/08/2015

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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 53 year old female who sustained an industrial injury on September 04, 1999. Recent primary treating office visit dated September 14, 2015 reported subjective complaint of "a lot of dizziness as well as tingling and numbness mostly on the left side." She is complaining of loss of balance. The plan of care is with requesting recommendation for pool therapy followed by land therapy sessions, cane DME assist with her balance, and pain management referral. On August 31, 2015 she underwent nerve conduction study which revealed normal findings. On July 24, 2015 she underwent neurological consultation that reported impression of: history of recent surgery to cervical region; subjective complaints of left side headaches with tingling sensation on the left side of face; lightheadedness and disequilibrium since recent surgery, and subjective complaint of numbness, tingling sensation and weakness in the left upper extremity. At primary follow up dated June 18, 2015 she was administered a trigger point injection to the posterior cervical paraspinal muscles. She is to continue with active physical therapy until maximum medical improvement reached with regard to motion, flexibility and strength. On September 26, 2015 a request was made for DME cane that was noncertified by Utilization review on September 30, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME Cane (Crutches Forearm, Includes Crutches of Various Materials Adjustable or Fixed): 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG knee, Cane (walking aids).

Decision rationale: MTUS is silent concerning canes. ODG states “Recommended as indicated below. Determination of causation typically involves mechanism of injury, temporal relationship, and dose effect.” In the general population, two thirds of meniscal tears occur in the absence of sporting activities, frequently during every day activities and in the absence of the classic injury mechanism. Ascent from a squat is a common mechanism of injury. (Drosos, 2004) ACL rupture is more common among those with symptomatic knee osteoarthritis (OA) compared with those without knee OA. Fewer than half of subjects with ACL rupture recall a knee injury, suggesting that this risk factor for knee OA is underrecognized. (Hill, 2005) The rate of ACL rupture is three times higher in female athletes than in male athletes. Intrinsic factors such as increased quadriceps angle and increased posterior tibial slope may predispose girls and women to ACL injury. Compared with males, females have smaller notch widths and smaller ACL cross-sectional area; however, no conclusive correlation between ACL size and notch dimension exists, especially in relation to risk of ACL injury. Female athletes who land with the knees in inadequate flexion and in greater-than-normal valgus and external rotation are at increased risk of ACL injury. Following ACL reconstruction, female athletes are more likely than male athletes to rupture the contralateral ACL; however, males and females are equally likely to rupture the reconstructed knee. (Sutton, 2013) A high quality study concluded that vigorous running activity over many years is not associated with an increase in knee pain with age, and there may be a moderate decrease in pain, particularly in women. (Fries, 1996) On the other hand, prolonged squatting is a strong risk factor for tibiofemoral knee osteoarthritis (OA) among the elderly, and accounts for a substantial proportion of the difference in prevalence of tibiofemoral OA between Chinese subjects in [REDACTED] and white subjects in [REDACTED]. (Zhang, 2004) For occupational activity, the [REDACTED] group states with a high level of scientific evidence that there is a relationship between occupational activity and osteoarthritis (OA) of the knee and hip. The precise nature of biomechanical stresses leading to OA remains unclear but factors such as high loads on the joint, unnatural body position, heavy lifting, climbing and jumping may contribute to knee and hip OA. The group recommends that taking an occupational history should always be part of managing the OA patient (Grade B). In the knee or hip OA patient, work-related activity that produces or maintains pain should be avoided (Grade B). Physicians should be alerted by the early knee and hip signs and symptoms in workers exposed to stresses that are known or supposed to favour knee or hip OA (Grade C). (Vignon, 2006) This study supports recommending regular moderate physical activity without undue fear that such activity may increase the risk for knee osteoarthritis (OA). Among middle-aged and elderly persons without knee OA in the [REDACTED] Offspring Study cohort, recreational exercise neither protected against nor increased risk for knee OA. Recreational walking, jogging, frequency of working up a sweat, or high activity levels relative to peers were not associated with decreased or increased risk for OA or with joint space loss. Overweight persons in this

cohort had no increases in risk for OA with different types of recreational activity. (Felson, 2007) Studies have suggested a higher risk of radiographic knee osteoarthritis (OA) with repetitive, high-impact sports, and this risk is most strongly associated with joint injury. A history of regular sports participation also has been shown to increase the odds of incident but not progressive radiographic OA. In contrast, moderate recreational physical exercise has been associated with decreased risk of knee OA requiring arthroplasty. (Foley, 2007) Knee osteoarthritis pathomechanics involves an interaction between abnormal and excessive and/or repetitive loading. Abnormal knee loading is not the only cause of articular cartilage disruption. Excessive and repetitive loading, together creating a total exposure to loading, are critical factors in knee pathomechanics. Although few reports explore the effect of a sedentary lifestyle on joints, more work has examined excessive physical activity. Running likely increases the risk for knee osteoarthritis in athletes, though this finding is not consistent. Among patients who report prolonged occupational kneeling and squatting, risk for developing knee osteoarthritis is elevated, particularly in the presence of obesity. An international systematic review states that there is a high degree of scientific evidence that sport activities increase risk for hip or knee osteoarthritis and this risk correlates with the intensity and duration of the activity. Yet, the precise dosage-response relationship between activity exposure and obesity in knee osteoarthritis progression remains understudied. (Maly, 2008) A high BMI is significantly associated with knee osteoarthritis (OA) and hand OA, but not with hip OA. A high BMI (> 30) had an odds ratio (OR) of 2.81 associated with knee OA, and a dose-response relationship was found for this association. Obesity was also significantly associated with hand OA (OR 2.59), but not with hip OA (OR 1.11). (Grotle, 2008) The results of this study of mechanisms of knee injury in runners relate larger knee joint loads to poor hamstring flexibility, greater body weight, greater weekly mileage, and greater muscular strength. (Messier, 2008) Knee dislocations are much more likely to be sports related than caused by motor vehicle accidents. (Bui, 2008) See also Work; & ODG Capabilities & Activity Modifications for Restricted Work. The treating physician has provided a medical rationale to meet the above guidelines. As such, the request for a cane is medically necessary.