

<b>Case Number:</b>	CM14-0155073		
<b>Date Assigned:</b>	10/09/2014	<b>Date of Injury:</b>	05/01/2002
<b>Decision Date:</b>	11/10/2014	<b>UR Denial Date:</b>	09/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2014

### 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 Internal Medicine and Pulmonary Disease 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 injured worker is a 53-year-old male who reported an injury on 05/01/2002. The mechanism of injury was not submitted for clinical review. The diagnoses included lumbago, low back pain, and RSD lower limb. Previous treatments included medication. Within the clinical note dated 09/23/2014, it was reported the injured worker complained of lower back pain. He described the pain as aching and constant. He also complained of feet pain. The injured worker complained of neck pain described as aching and constant. He rated his pain 7/10 in severity. Upon the physical examination, the provider noted the injured worker had tenderness and decreased range of motion, with flexion and extension of the cervical spine. The provider noted that the injured worker was utilizing crutches. The provider noted that the injured worker had tenderness of the lumbar spine and tenderness of the facet joints, with decreased range of motion of flexion and extension. Provider requested new crutches, since the old ones are worn, and Methadone. The Request for Authorization was submitted and dated 10/17/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Set of Crutches:** Upheld

**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 & Leg (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Walking aids (Canes, Crutches, Braces, Orthoses, & Walkers)

**Decision rationale:** The request for 1 set of Crutches is not medically necessary. The Official Disability Guidelines note walking aides are determined by disability, pain, and age related impairment seem to determine the need for a walking aid. Assistive devices for ambulation can reduce pain associated with osteoarthritis. Frames or wheeled walkers are preferable for patients with bilateral disease. No significant neurological deficits of the lower extremities warrant the medical necessity for additional crutches. The provider failed to document that the injured worker is currently utilizing the use of crutches; therefore, the request is not medically necessary.

**1 prescription of Methadone 10mg #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use, On-Going Management Page(s): 77-78.

**Decision rationale:** The request for Methadone 10 mg #180 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication is evidence based with significant functional improvement. The request submitted failed to provide the frequency of the medication. The use of a urine drug screen was not submitted for clinical review. Additionally, the provider failed to document an adequate and complete pain assessment within the documentation. Therefore, the request is not medically necessary.