

Case Number:	CM15-0128607		
Date Assigned:	07/15/2015	Date of Injury:	09/28/2013
Decision Date:	08/11/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/02/2015

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, Hawaii

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 38 year-old female who sustained an industrial injury on 09/28/13. She reported an injury to the neck, right upper extremity, low back, and right knee status post fall. Initial diagnoses included contusion of the back, and discogenic/degenerative changes of the lumbar spine. Current diagnoses include lumbago, arthropathy, fibromyalgia, coccygodynia, patellofemoral pain, cubital tunnel syndrome, and gastritis/gastroduodenitis. Diagnostic testing and treatments to date have included physical therapy, acupuncture, psychological evaluation, and pain medication management. Currently, the injured worker complains of increased neck, shoulder and back pain. Physical examination is remarkable for positive Straight Leg Raise, Patrick's, facet loading, and Spurling's test. Cross-body test is positive for bilateral shoulders, and there is weakness in bilateral hip flexion. She has clinical evidence for disc herniation. Plan of care is lumbar injections to avoid lumbar surgery. Requested treatments include a walking cane and urinalysis drug screen. The injured worker is under temporary total disability. Date of Utilization Review: 06/16/15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Walking 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 (ODG), Walking aides.

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 (Acute & Chronic), Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: ODG states, "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. 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. 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." The medical documentation provided do not indicate any instability that would require the assistance of a cane. There are no objective findings or subjective complaints to substantiate the need for this request. As such, the request for walking cane is not medically necessary.

Urine drug screening: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 111-113, Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-82. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Drug testing, Opioids, screening for risk of addiction, differentiation dependence & addiction, Urine drug testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and Substance abuse Page(s): 74-96; 108-109. Decision based on Non-MTUS Citation University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009), pg 32 Established Patients Using a Controlled Substance.

Decision rationale: MTUS states that use of urine drug screening for illegal drugs should be considered before therapeutic trial of opioids are initiated. Additionally, use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion) would indicate need for urine drug screening. There is insufficient documentation provided to suggest issues of abuse, addiction, or poor pain control by the treating physician. University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009) recommends for stable patients without red flags twice yearly urine drug screening for all chronic non-malignant pain patients receiving opioids once during January-June and another July-December. The patient has been on chronic opioid therapy. The treating physician has not indicated why a urine drug screen is necessary at this time and has provided no evidence of red flags. As such, the request for Urine drug screening is not medically necessary.