

<b>Case Number:</b>	CM15-0143106		
<b>Date Assigned:</b>	08/04/2015	<b>Date of Injury:</b>	10/01/1990
<b>Decision Date:</b>	09/29/2015	<b>UR Denial Date:</b>	07/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2015

### 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 York  
 Certification(s)/Specialty: Internal 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 59 year old male who sustained an industrial injury on 10-1-90. The injured worker was diagnosed as having chronic pain, cervical radiculitis, cervical strain-sprain, lumbar post laminectomy syndrome, lumbar radiculopathy, chronic constipation, depression and hemorrhoids. Currently, the injured worker reported pain in the neck, low back and left upper extremity and shoulder. Previous treatments included injections, wheelchair, and sling, oral pain medication a cane and activity modification. Previous diagnostic studies included radiographic studies. The injured work status was noted as permanent and stationary. The injured workers pain level was noted as 9 out of 10 with medication and 10 out of 10 without medication. Physical examination was notable for tenderness to the spinal vertebra at C5 to C7 and the left shoulder, range of motion limited at the cervical spine, straight leg raise in seated position was positive bilaterally at 30 degrees, unable to stand without assistance, left upper extremity with sling present. Of note, provider documentation revealed the injured workers wheelchair was recently fixed but suddenly broke on 6-23-15, notation was made that the injured worker was "awaiting repair of electric wheelchair within the week". The plan of care was for a lumbar orthosis x 1, a left shoulder sling, a new motorized wheelchair x 1, Oxycodone 10-325 milligrams quantity of 150, Flector patch 1.3% quantity of 60 and Savella 50 milligrams quantity of 90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar orthosis x 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 205.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar supports.

**Decision rationale:** MTUS states that the use of Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Per guidelines, lumbar supports may be recommended as an option for compression fractures and specific treatment of spondylolisthesis and documented instability. Long-term use of lumbar supports is not recommended. Chart documentation does not indicate any acute objective findings to justify the use of lumbar support to treat the injured worker's chronic complaints of back pain. Subsequently, the request for lumbar orthosis x 1 is not medically necessary.

**Left shoulder sling: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), shoulder (acute and chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205. Decision based on Non-MTUS Citation Official Disability Guide, Shoulder (Acute & Chronic).

**Decision rationale:** Per guidelines, immobilization and rest are not recommended as a primary treatment. Early mobilization benefits include earlier return to work, decreased pain, swelling, and stiffness, and a greater preserved range of joint motion, with no increased complications. MTUS states that the shoulder joint can be kept at rest in a sling if indicated. Gentle exercise even during this time is desirable. Patients acutely should avoid activities that precipitate symptoms, but should continue general activities and motion. It is recommended that Therapeutic exercise, including strengthening, be initiated as soon as it can be done without aggravating symptoms. The injured worker complains of chronic pain in the neck, low back, left upper extremity and shoulder. Being that symptoms are chronic and ongoing, the medical necessity for shoulder sling has not been established. The request for a left shoulder sling is not medically necessary.

**New motorized wheelchair x 1: 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), ankle and foot (acute and chronic): power mobility devices.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Device Page(s): 99.

**Decision rationale:** The request is for a new motorized wheelchair x 1. Currently, the injured worker reported pain in the neck, low back and left upper extremity and shoulder. CA MTUS recommendations state that power mobility devices are "not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." In this case, physical examination does not reveal the injured worker being unable to use a cane or walker, or that the injured worker has upper extremity strength issues to not be able to handle a manual wheelchair. Additionally, provider documentation revealed the injured worker's wheelchair was recently fixed but suddenly broke on 6-23-15, and was "awaiting repair of electric wheelchair within the week". As such, the request for a new motorized wheelchair x 1 is not medically necessary.

**Oxycodone 10/325mg #150:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

**Decision rationale:** MTUS recommends that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented with the use of Opioids. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guidelines recommend using key factors such as pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors, to monitor chronic pain patients on opioids. Assessment for the likelihood that the patient could be weaned from opioids is recommended if there is no overall improvement in pain or function, unless there are extenuating circumstances and if there is continuing pain with the evidence of intolerable adverse effects. Documentation fails to demonstrate adequate improvement in the injured worker's level of function or pain, to support the medical necessity for continued use of opioids. In the absence of significant response to treatment, the request for Oxycodone 10/325mg #150 is not medically necessary.

**Flector patch 1.3% #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain (chronic) Flector.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Flector Patch.

**Decision rationale:** Flector patch (Diclofenac) is FDA indicated for acute strains, sprains, and contusions and recommended for osteoarthritis after failure of an oral NSAID or when there is contraindication to oral NSAIDs. Per ODG, Flector Patch is not recommended for use as a first-line treatment. The guidelines specifically indicate that "There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder." Documentation fails to demonstrate adequate improvement in the injured worker's level of function or quality of life, to support the medical necessity for continued use of Flector Patch. In the absence of significant response to treatment, the request for Flector patch 1.3% quantity of 60 is not medically necessary.

**Savella 50mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain (chronic): Milnacipran.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Procedure Summary, Milnacipran (Savella).

**Decision rationale:** Savella (Milnacipran) is a serotonin and norepinephrine reuptake inhibitor (SNRI), designed to be more effective than selective serotonin reuptake inhibitors (SSRIs) and better tolerated than tricyclic antidepressants (TCAs). It is FDA approved for the management of fibromyalgia. ODG does not recommend Savella for chronic pain. As there is little to no evidence that the cause of fibromyalgia is related to industrial injuries, it is recommended that the use of Savella be restricted to documented cases of fibromyalgia as part of an appropriate treatment plan. Documentation fails to show that the injured worker is diagnosed with fibromyalgia. The medical necessity for Savella has not been established. The request for Savella 50mg #90 is not medically necessary per guidelines.