

Case Number:	CM15-0006769		
Date Assigned:	01/26/2015	Date of Injury:	03/17/2014
Decision Date:	03/17/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/13/2015

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: Colorado

Certification(s)/Specialty: Family Practice

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 57 year old male injured worker suffered an industrial injury on 3/17/2014, also described as the results of cumulative trauma 3/17/2013-3/17/2014. The diagnosis was Pain Shoulder (Primary), right shoulder arthroscopic decompression. The diagnostics were x-rays and electromyography. The treatments included right shoulder arthroscopy 6/17/2014, physical therapy, home exercise program, sling, ice, and TENS unit, as well as documented Norco prescriptions. The Orthopedic provider treating the shoulder reported right shoulder pain 5/10, tenderness and limited range of motion. The injured worker reported improvement with the medications and Physical Therapy. In addition to treatment for shoulder pain, patient was following with another Orthopedic provider as treating physician for bilateral knee pain and bilateral hand pain, and medications prescribed including Cyclobenzaprine, Naproxen, Protonix, and Tramadol ER 300mg daily. The Utilization Review Determination on 12/31/2014 non-certified Tramadol ER 150mg #40, citing MTUS Chronic Pain Treatment Guidelines, Opioids.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER 150 mg #40: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 79-80, 85, 88-89, and 93-94.

Decision rationale: Tramadol is a synthetic opioid that exerts its effect on the central nervous system. The MTUS Guidelines establish criteria for use of opioids, including long term use (6 months or more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated clinical assessment tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids. 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits serious non-adherence or misuse. Per the Guidelines, Chelminski defines serious substance misuse as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work? Has patient had improved function and decreased pain with the opioids? For the patient of concern, the records indicate 2 Orthopedic providers follow the patient, his shoulder surgeon and another Orthopedist (general) focusing primarily on his hand pain / knee pain / medication management. While patient's general Orthopedic provider reviews patient's pain medication regimen extensively every visit and documents discussions of side effects, aberrant

drug taking behavior, pain contract adherence, and improvements in pain and function in detail, he does not address the conflict in the record with patient's shoulder surgeon records. Patient has multiple clinic notes since August 2014 that document that patient's shoulder surgeon started Norco and continues to prescribe. However, neither his notes nor the notes of the general Orthopedic provider address ongoing use of both Norco and Tramadol ER. In fact, the general Orthopedic provider specifically documents, more than once, that patient has been able to discontinue his "immediate release opioid" because of his improvement with Tramadol ER. Only 1 urine drug screen has been documented and it was positive for Tramadol and Cyclobenzaprine, at a time when he was receiving Norco for routine use per shoulder surgeon notes. As the record is unclear if patient is to be using both medications, and there is no clear documentation that the 2 prescribing providers are aware of each other's prescriptions / plans, the request for Tramadol ER is not medically indicated.