

<b>Case Number:</b>	CM15-0161757		
<b>Date Assigned:</b>	08/27/2015	<b>Date of Injury:</b>	05/07/2006
<b>Decision Date:</b>	09/30/2015	<b>UR Denial Date:</b>	08/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/17/2015

### 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: North Carolina

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 injured worker is a 57 year old male, who sustained an industrial injury on 5-07-2006. He reported repetitive movement while working at a carnival. The injured worker was diagnosed as having left shoulder adhesive capsulitis, left shoulder rotator cuff syndrome, rule out tear, status post left shoulder manipulation under anesthesia, arthroscopic subacromial decompression, arthroscopic lysis of adhesions on 11-21-2006, and status post left shoulder arthroscopy with subacromial decompression, lysis of adhesions, capsular release, and manipulation under anesthesia on 1-03-2007. Treatment to date has included diagnostics, surgical intervention, physical therapy, steroid injections, and medications. Currently, the injured worker complains of persistent left shoulder pain, rated 8-9 out of 10. His medication use included Motrin, which decreased pain to 5-6 out of 10 and allowed him to do basic activities of daily living and continue working. Pain was made worse with activity and weather changes. Exam of the left shoulder noted decreased range of motion, tenderness to palpation and hypertonicity of the trapezius, positive Neer's and Hawkin's tests, and 4 out of 5 muscle strength. The treatment plan included consultation with a shoulder specialist, regarding the left shoulder for possible total shoulder replacement, and urine toxicology screening as a part of pain management agreement during opioid therapy. No signs of diversion were noted and the use of Tramadol was dispensed and referenced as used on an as needed basis on 5-07-2015. A steroid injection to the left shoulder was noted on 5-07-2015. His work status remained full duty. A previous PR2 report (6-10-2015) noted that he was not doing home exercises or icing, stating that it does not help.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Consultation with a shoulder specialist, quantity: 1, per 07/23/15 order:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines: Chapter 7, Independent Medical Evaluations and Consultations, Page 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 3 Initial Approaches to Treatment.

**Decision rationale:** Per the ACOEM : The health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for 1. Consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient has ongoing complaints of shoulder pain that have failed treatment by the primary treating physician. Therefore, criteria for a shoulder specialist consult have been met and the request is medically necessary.

**Urine toxicology screen, quantity: 1, per 07/23/15 order:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-80 and 94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). 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) (d)

Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The California MTUS does recommend urine drug screens as part of the criteria for ongoing use of opioids .The patient was on opioids at the time of request and therefore the request is medically necessary.