

<b>Case Number:</b>	CM15-0183550		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	10/14/2010
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	08/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 48 year old female injured worker suffered an industrial injury on 10-14-2010. The diagnoses included cervical spine sprain-strain with right upper extremity radiculopathy, complex regional pain syndrome of the right upper extremity and DeQuervain's tenosynovitis of the right wrist. On 4-7-2015 the provider noted that the care in the home was for rehabilitative, therapeutic, assistive and supportive care including wound care, pain management, medications administration and assistance with home exercises. In addition to medical care he noted the injured worker will also need daily care to help insure that the activities of daily living were met including self-care and household support services. On 8-7-2015 the treating provider reported right shoulder pain. On exam the right upper extremity was tender with some swelling and decreased range of motion. The cervical spine was tender with decreased range of motion. The pain with medication was 5 out of 10 and without medications 9 out of 10 lasting 6 hours. The provider noted no aberrant drug behavior. He noted improvement in ability to do house work and participation in home exercises with medication. Prior treatment included Ultram since at least 1-2015. The Utilization Review on 8-28-2015 determined non-certification for Ultram ER 150mg #30, Continue home care; 4 hours/day, 3 days/week for 6 weeks, and Replacement of stolen-home interferential stimulator unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram ER 150mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain, Opioids, criteria for use, Opioids for chronic pain.

**Decision rationale:** The 48 year old patient complains of pain in cervical spine, right shoulder, and right forearm, as per progress report dated 08/07/15. The request is for Ultram ER 150mg #30. The RFA for this case is dated 08/07/15, and the patient's date of injury is 10/14/10. Diagnoses, as per progress report dated 08/07/15, included cervical sprain/strain with right upper extremity radiculopathy, right upper extremity reflex sympathetic dystrophy syndrome/complex regional pain syndrome, and left upper extremity overuse syndrome. The patient is status post right shoulder arthroscopy on 11/30/11, as per progress report dated 08/07/15. Medications included Ultram, Neurontin, Motrin, Sonata and Lidoderm patch. The patient is temporarily totally disabled, as per the same progress report. MTUS, Criteria for use of Opioids Section, pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS, Criteria for use of Opioids Section, page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS, Criteria for use of Opioids Section, p77, states that "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS, Medications for chronic pain Section, page 60 states that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity." MTUS, page 113 regarding Tramadol (Ultram) states: Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. For more information and references, see Opioids. See also Opioids for neuropathic pain. In this case, several reports are handwritten and difficult to decipher. A prescription for Ultram is first noted in progress report dated 06/25/14. It is not clear when opioids were initiated. As per progress report dated 08/07/15, medications help reduce pain from 9/10 to 5/10 without side effects and aberrant behavior. The patient is better able to do housework and has improved participation in HEP. In progress report dated 06/08/15, the treater states that Ultram has been "helpful together with physical therapy in allowing her to perform activities of daily living despite having continuous pain experience". A request for urine toxicology screening is also noted in the same report. In a report dated 04/07/15, the treater states that Ultram provided "adequate degree of analgesic relief; the patient was also able to function adequately. In fact the patient was able to carry out and tolerate her exercises and activities of daily living with minimal discomfort". Ultram did not cause any adverse side effects or aberrant behavior. The treater, however, does not document objective functional improvement using validated instruments, or questionnaires with specific categories for continued opioid use. MTUS requires specific examples that indicate an improvement in function and states that "function should include

social, physical, psychological, daily and work activities." In this case, treater has not addressed the 4A's adequately to warrant continued use of this medication. Hence, the request is not medically necessary.

**Continue home care; 4 hours/day, 3 days/week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

**Decision rationale:** The 48 year old patient complains of pain in cervical spine, right shoulder, and right forearm, as per progress report dated 08/07/15. The request is for Continuous home care; 4 hours/day, 3 days/week for 6 weeks. The RFA for this case is dated 08/07/15, and the patient's date of injury is 10/14/10. Diagnoses, as per progress report dated 08/07/15, included cervical sprain/strain with right upper extremity radiculopathy, right upper extremity reflex sympathetic dystrophy syndrome/complex regional pain syndrome, and left upper extremity overuse syndrome. The patient is status post right shoulder arthroscopy on 11/30/11, as per progress report dated 08/07/15. Medications included Ultram, Neurontin, Motrin, Sonata and Lidoderm patch. The patient is temporarily totally disabled, as per the same progress report. MTUS Chronic Pain Medical Treatment Guidelines 2009, pg 51 for Home health services states: "Recommended only for otherwise recommended medical treatment for patients who are home bound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed." In this case, several reports are handwritten and difficult to decipher. In a report dated 04/07/15, the treater is requesting for "rehabilitative, therapeutic, assistive and supportive care in the home". The treater states that the patient needs help with wound care, medication administration, pain management, and assistance with home exercises. The treater states that the patient will also need help with "self care and household support services". In progress report dated 06/08/15, the treater states "the patient needs assistance from a member of the home health care team that would provide re-assurance that her needs will be met and her home exercise program will be guided by a knowledgeable home health care provider who is in the right position to carry out these tasks properly and effectively without the risk of re-injury". However, in progress report, dated 08/07/15, the treater is requesting for home health care to "cook/clean/laundry/meal prep". The patient does suffer from chronic pain which has limited the patient's functionality. MTUS, however, does not consider homemaker services, including cooking, laundry and cleaning, as medial treatments. Hence, the request is not medically necessary.

**Replacement of stolen-home interferential stimulator unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** The 48 year old patient complains of pain in cervical spine, right shoulder, and right forearm, as per progress report dated 08/07/15. The request is for Replacement of stolen-home interferential stimulator unit. The RFA for this case is dated 08/07/15, and the patient's date of injury is 10/14/10. Diagnoses, as per progress report dated 08/07/15, included cervical sprain/strain with right upper extremity radiculopathy, right upper extremity reflex sympathetic dystrophy syndrome/complex regional pain syndrome, and left upper extremity overuse syndrome. The patient is status post right shoulder arthroscopy on 11/30/11, as per progress report dated 08/07/15. Medications included Ultram, Neurontin, Motrin, Sonata and Lidoderm patch. The patient is temporarily totally disabled, as per the same progress report. MTUS Chronic Pain Medical Treatment Guidelines 2009, Transcutaneous electrotherapy section, pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person." In this case, several reports are handwritten and difficult to decipher. The request of replacement of the IF unit to "help alleviate muscle pain/spasm and improve overall functional status" is noted in progress report dated 08/07/15. However, it is not clear how the previous IF unit was used. The treater does not document objective functional improvement, reduced pain, and lower medication use from prior use. Given the lack of relevant documentation the request for a new IF unit is not medically necessary.