

<b>Case Number:</b>	CM15-0128399		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	07/18/2006
<b>Decision Date:</b>	08/12/2015	<b>UR Denial Date:</b>	06/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2015

### 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: Preventive Medicine, Occupational 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 53 year old male who sustained an industrial /work injury on 7/18/06. He reported an initial complaint of bilateral hand/wrist and shoulders. The injured worker was diagnosed as having bilateral carpal tunnel syndrome, right shoulder glenoid labral tear, right shoulder rotator cuff tear and right shoulder impingement syndrome. Treatment to date includes medication, modified duties, surgery (right shoulder arthroscopy with repeat subacromial decompression, debridement of a partial rotator cuff tear and repeat superior glenoid labral repair on 1/17/11. Currently, the injured worker complained of mild pain in both shoulders, R>L, and worse with overhead activities. Per the primary physician's report (PR-2) on 5/28/15, exam noted minimally decreased range of motion and mildly positive Tinel's, Phalen's and carpal compression tests of both hands. There are no motor and sensory deficits through C4-T1. There is negative impingement sign and Neer test of the right shoulder. Current plan of care included medication. The requested treatments include Ultracet tab 37.5/325 mg by mouth every 8 hours as needed for pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultracet tab 37.5/325 mg Qty 60 with 1 refill, 1 by mouth every 8 hrs as needed for pain:**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram); Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain - Opioids.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. The MTUS states that opioids may be continued, (a) If the patient has returned to work, or (b) If the patient has improved functioning and pain. The patient fits both of these criteria. Patient has noted significant objective functional improvement with the use of Ultracet. He is currently working. I am reversing the previous utilization review decision. Ultracet tab 37.5/325 mg Qty 60 is medically necessary.