Case Number:	CM15-0178110		
Date Assigned:	09/18/2015	**Date of Injury:**	10/30/2014
Decision Date:	10/21/2015	**UR Denial Date:**	08/13/2015
Priority:	Standard	**Application Received:**	09/10/2015

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 60 year old female, who sustained an industrial injury on October 30, 2014 and reported left shoulder, left ankle, left foot and left jaw pain as well as a hearing complaint. The injured worker is currently diagnosed left foot crush injury, left shoulder contusion, left shoulder sprain-strain, left impingement syndrome and left ankle sprain. Her work status is full duty. Currently, the injured worker complains of left shoulder pain with a loss of range of motion and stiffness. She reports moderate, frequent left foot pain, loss of range of motion and swelling. The pain is described as sharp and rated at 6-7 on 10. She also reports constant, moderate left ankle pain. She reports her pain is reduced from 7-8 on 10 to 4-5 on 10 with pain medication that lasts for 4 to 6 hours, which allows her to engage in her home exercise program. Physical examinations dated May 26, 2015- July 27, 2015 revealed crepitus in the left shoulder as well as tenderness to palpation over the acromioclavicular joint, subacromial region and supraspinatus tendon. There is slight muscle spasm in the "rhomboid muscle and left trapezius muscle". Cross arm and impingement tests are positive. Left shoulder range of motion is as follows; flexion 100 degrees, extension 15 degrees, abduction 100 degrees, adduction 20 degrees, internal rotation 65 degrees and external rotation 65 degrees. Left shoulder muscle weakness is 4 on 5 in flexion, extension and abduction. There is swelling over the "lateral greater than medial" ankle and "diffuse" tenderness over the left foot and ankle. Left foot and ankle muscle weakness is 4 on 5 in all of the "planes of motion". The left foot reveals tenderness to palpation over the second to fourth "metatarsals" and is present over the "plantar region". Left ankle range of motion is as follows; extension 10 degrees, flexion 20 degrees, inversion 18

degrees and eversion 15 degrees. Treatment to date has included physical therapy for her left foot with good results, including decreased pain and improved range of motion; however, she continues to experience frequent pain and swelling, per note dated June 18, 2015. The note also states left shoulder physical therapy has improved range of motion, but she continues to experience pain. The medications; Ultram (for at least 4 months) and Zanaflex are prescribed for pain and spasms. She has had x-rays and engages in a home exercise program. An MRI of the left shoulder dated June 1, 2015 "strongly suggests a distal anterior tear of the supraspinatus", "diffuse moderate fluid through the subacromial-subdeltoid bursa suspected secondary to joint decompression through the rotator cuff", "OS acromial", "mild degenerative change at the AC joint, intact but attenuated in size proximal extracapsular course of the biceps tendon" and "moderate atrophy of the supraspinatus and milder atrophy of the infraspinatus muscles". A request for Ultram 50 mg #120 is modified to #80 as a CURES report, recent drug screen, discussions regarding weaning, changing medication, orientation, functionality and-or benefit from medication was not provided, per Utilization Review letter dated August 13, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram 50 mg #120: 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): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include:
(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from 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 dairy 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 non-opioid 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. When to Continue Opioids: (a) If the patient has returned to work. (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004)The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant decrease in objective pain measures such as VAS scores for significant periods of time .There are no objective measures of improvement of function or how the medication improves activities. The work status is not mentioned. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.