

Case Number:	CM14-0038052		
Date Assigned:	09/23/2014	Date of Injury:	05/20/2008
Decision Date:	10/22/2014	UR Denial Date:	03/19/2014
Priority:	Standard	Application Received:	04/01/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 68-year-old male who reported an industrial injury on 12/10/2010, almost four (4) years ago, attributed to the performance of his usual and customary job duties. The clinical narrative dated 3/4/2014 reported that the patient had not been evaluated in the prior three (3) years. The treating diagnoses had been brachial plexopathy; cervical spine DDD; status post rotator cuff repair; and radiculopathy. The patient was noted to have reported that he had use Norco for slight pain occasionally but had itching when he took the medicine and wanted a change. The patient was noted to have a diminished range of motion to the postoperative shoulder from 2008. The patient was reported to be stabilized on Nucynta and therapeutic compounded analgesic creams while being treated under the provisions for future medical care. The patient was prescribed a TENS unit directed to the postoperative shoulder and Nucynta for pain to replace Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit for right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 203, 300, Chronic Pain Treatment Guidelines TENS

unit chronic pain Page(s): 114-117. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) forearm, wrist, hand--TENS unit; Pain chapter--TENS unit

Decision rationale: The requesting provider did not provide subjective/objective evidence to support the medical necessity of the TENS Unit or the electronic muscle stimulator for the treatment of the postoperative right shoulder. The ACOEM Guidelines do not recommend the use of TENS Units for neck, shoulder, elbow, or wrist as there is no objective evidence available to support their use. There is no justification for the use of the 4-lead TENS unit as required by the CA MTUS. The use of the TENS unit for the treatment for the wrist/hand/forearm is not recommended by the CA MTUS or the ACOEM Guidelines. There is no objective evidence provided to support the medical necessity of the requested TENS Unit or electric muscle stimulator for the treatment of the hand/forearm for the effects of the industrial injury. The TENS unit is directed to chronic right postoperative shoulder pain issues. The patient was noted to have used a TENS unit during PT rehabilitation; however, there was no documented functional improvement with the use of the tens unit and no demonstrated reduction in the use of medications for the postoperative shoulder for the left shoulder. There was no objective evidence to justify the continued use of the tens unit in the treatment plan for this patient. The CA MTUS and the Official Disability Guidelines only recommends the use of the TENS unit for chronic lower back pain with a demonstrated exercise program for conditioning and strengthening. The TENS Unit is recommended for only chronic intractable pain. There was no provided documentation that the patient was participating in a self-directed home exercise program. The ACOEM Guidelines revised back chapter 4/07/08 does recommend the use of the TENS Unit for the treatment of chronic lower back pain; however, it must be as an adjunct to a functional rehabilitation program and ongoing exercise program. The CA MTUS only recommend the use of the TENS unit for chronic lower back pain with a demonstrated exercise program for conditioning and strengthening. There are no recommendations for the use of the TENS Unit in the treatment of the wrist, forearm, or hand. There is no objective evidence provided by the requesting provider that the same results cannot be achieved with a home exercise program established for functional rehabilitation with strengthening and conditioning directed to the hand. There is no demonstrated medical necessity for the provision of a TENS for the rehabilitation of the shoulder for years after the date of surgery for the reported chronic pain status post right shoulder arthroscopy.

Nucynta, quantity no specified: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-306, Chronic Pain Treatment Guidelines Opioids Page(s): 74-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter Opioids, American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6.

Decision rationale: The prescription for Nucynta is being prescribed as opioid analgesics for the treatment of chronic pain against the recommendations of the ACOEM Guidelines. There is no objective evidence provided to support the continued prescription of opioid analgesics for

chronic mechanical back or leg pain. The patient is prescribed opioid analgesics four (4) years after the DOI. There is no demonstrated medical necessity to prescribe the patient high doses of opioids. The patient was noted to have been previously prescribed Norco, which he used only occasionally; however, he reported having itching and was thus prescribed Nucynta. The treatment of mechanical neck and shoulder pain with opioids is not recommended. The patient is treated high dose opioids for the treatment of mechanical back pain; however, there is no demonstrated functional improvement and even with the cited high doses; the patient still reports pain and lack of function from his prescribed medications. The chronic use of Nucynta is not recommended by the CA MTUS, the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic back pain and is only recommended as a treatment of last resort for intractable pain. The prescription of Nucynta is inconsistent with the recommendations of evidence-based guidelines for the treatment of mechanical back pain. The prescription of opiates on a continued long-term basis is inconsistent with the CA MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain. The current prescription of opioid analgesics is not consistent with evidence-based guidelines based on intractable pain. The ACOEM Guidelines updated chapter on chronic pain states, "Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues; such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect." ACOEM guidelines state that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, if: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also notes, "Pain medications are typically not useful in the subacute and chronic phases and have been shown to be the most important factor impeding recovery of function." Evidence-based guidelines recommend: Chronic back pain: Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. The ODG states that chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment

effect. (Ballantyne, 2006) (Furlan, 2006) Long-term, observational studies have found that treatment with opioids tends to provide improvement in function and minimal risk of addiction, but many of these studies include a high dropout rate (56% in a 2004 meta-analysis). (Kalso, 2004) There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain. (Martell-Annals, 2007) (ODG, Pain Chapter). There is no demonstrated medical necessity for the prescribed Nucynta for the effects of this industrial injury.