

Case Number:	CM15-0186404		
Date Assigned:	09/28/2015	Date of Injury:	05/02/2014
Decision Date:	11/03/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/22/2015

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 27 year old male, who sustained an industrial injury on 5-2-2014, resulting in initial swelling and tingling of his hands with activity with pain and loss of sensation in his fingertips. A review of the medical records indicates that the injured worker is undergoing treatment for carpal tunnel syndrome and moderate bilateral median neuropathy. On 9-4-2015, the injured worker reported progressive bilateral wrist and hand pain. The Primary Treating Physician's report dated 9-4-2015, noted the injured worker's pain level had remained unchanged since the previous visit, with the injured worker rating his pain without medications as 8 on a scale of 1 to 10, with decreased activity level and poor quality of sleep. The injured worker's current medications were listed as Ultram and Zipsor. The physical examination was noted to show the injured worker appeared to be in mild distress and in moderate pain. The examination of the bilateral wrists was noted to show positive Phalen's and Tinel's with tenderness to palpation noted over the radial and ulnar sides. The injured worker was noted to be wearing bilateral hard wrist splints-braces. The sensory examination was noted to show decreased light touch sensation over the bilateral thumbs. "Conservative treatments" included six sessions of physical therapy which was noted to provide the injured worker with mild pain relief. The treatment plan was noted to include discontinuation of Tramadol as it was noted to be ineffective, continued Zipsor, prescribed since 4-7-2015, and a Trial of Nucynta for pain. The injured worker was noted to be stable with an improved quality of life and increased capability for daily activities with the medication regimen, with functional improvement over baseline noted. A signed opiate agreement was noted to be on file. The injured worker's work status was noted to be temporarily totally disabled. The 6-5-2015 Primary Treating Physician's report noted the injured worker rating his pain with medications as 6 on a scale of 1 to 10 and 8 without

medication, with the activity level noted to have remained the same. The request for authorization was noted to request 60 Tablets of Nucynta 50mg and 90 Capsules of Zipsorn 25mg. The Utilization Review (UR) dated 9-14-2015, modified the request for 60 Tablets of Nucynta 50mg with approval for 13 tablets and non-certified the request for 90 Capsules of Zipsorn 25mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 Tablets of Nucynta 50mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 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 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 documentation of significant subjective improvement in pain such as VAS scores. There is also no objective measure of improvement in function. For these reasons the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore, the request is not medically necessary.

90 Capsules of Zipsorn25mg: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The California chronic pain medical treatment guidelines section on NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) This medication is recommended for the shortest period of time and at the lowest dose possible. The shortest period of time is not defined in the California MTUS. The requested medication is within the maximum dosing guidelines per the California MTUS. Therefore, the request is medically necessary.