

Case Number:	CM14-0154526		
Date Assigned:	09/24/2014	Date of Injury:	04/17/1996
Decision Date:	10/24/2014	UR Denial Date:	08/30/2014
Priority:	Standard	Application Received:	09/22/2014

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 53-year-old female patient who reported an industrial injury on for/17/1996, over 18 years ago, attributed to the performance of her usual and customary job duties. The patient complained of bilateral upper extremity symptoms along with migraine headaches. The patient was diagnosed with thoracic outlet syndrome and underwent two surgical interventions for thoracic outlet syndrome. The patient was noted to have failed a spinal cord stimulator trial. An AME evaluation recommended that the patient did not use of opioids. The patient was increased to Nucynta 100 mg TID which resulted in a pain level of 7/10, whereas, the pain level was 10/10 without medications. The patient reported she was unable to sleep without taking Ambien. The patient was noted to have been previously prescribed Percocet; Methadone; Vicodin; and Darvon. The objective findings on examination included cervical spine with no para cervical muscle tenderness; normal range of motion; lumbar spine nontender to palpation; normal extension; normal range of motion; limited range of motion of wrist bilaterally; hypersensitivity to skin overlying forearms bilaterally, allodynia and hyper anesthesia in upper extremities; no temperature changes; no skin modeling; no neurological deficits. The assessment included neuralgia; carpal tunnel syndrome; cervical spine radiculopathy; insomnia; chronic migraine headaches; opioid dependence; and hypertension. The patient is treated for chronic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nucynta ER (Tapentadol) 100mg, 1 tab every 12 hours #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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 ACOEM Practice Guidelines, Chapter 6 pages 114-16, and on the Official Disability Guidelines (ODG), Pain chapter, opioids

Decision rationale: The prescription for Nucynta 100 mg #60 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 upper extremity pain. The patient is prescribed opioid analgesics 18 years after the DOI. There is no demonstrated medical necessity to prescribe the patient high doses of opioids. The treatment of bilateral upper extremity pain with opioids is not recommended. The patient is treated high dose opioids for the treatment of bilateral upper extremity 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 her 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 UE 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 BUE 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 (\approx 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 continued prescription of Nucynta 100 mg b.i.d. #60.