MAXIMUS Federal Services

Case Number:	CM15-0122685		
Date Assigned:	07/06/2015	Date of Injury:	03/01/2013
Decision Date:	09/01/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	06/25/2015

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: New York
Certification(s)/Specialty: Pediatrics, Internal 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 57 year old female, who sustained an industrial injury on 03/01/2013. She reported injury to the wrists. Treatment to date has included therapy, TENS unit, massage, injection, surgery, physical therapy and medications. Medications used during history of treatment have included Lidoderm, Tylenol with codeine, Norco, Flexeril, Gabapentin, Lyrica and Cymbalta. She could not tolerate Ultram because of blurry vision and severe urinary retention. Gabapentin helped but was sedating. Cymbalta, Lyrica and Tylenol with codeine did not help. According to a progress report dated 04/15/2015, pain remained constant and was described as burning, throbbing, achy, dull, electric and pins/needles. Overuse exacerbated her pain while rest alleviated it. She was currently using Norco per her primary medical doctor. Pain was rated 4/8 on a scaled of 1-10. Diagnoses included carpal tunnel syndrome, pain in joint forearm, pain in joint hand and unspecified myalgia/myositis. It was recommended that the injured worker keep a pain diary. Recommendations included a trial of Nucynta IR 50mg #60 and hold Norco per primary medical doctor. She was scheduled for a right radial nerve block with ultrasound guidance on 05/06/2015. On 05/13/2015, progress notes indicated that Nucynta IR was not authorized and that the injured worker requested to return to Norco and have that office prescribe the medication. Nucynta IR was discontinued because it was not authorized. A prescription was given for Norco 10/325mg 1 by mouth daily twice a day #60. The provider also noted Nucynta (tapentadol) 50mg 1 tablet by mouth twice a day fill #60 start on 05/13/2015. On 05/22/2015, the provider noted that Nucynta IR and Norco were not authorized. The treatment plan included Vicodin 5/325mg 1 by mouth twice a day #60 and Gabapentin 100mg 1 by mouth

twice a day #60. A stellate ganglion block was requested to help determine etiology of pain and give relief if positive. She had symptoms very compared with complex regional pain syndrome. She had not had relief with previous radial nerve block. On 05/27/2015, the provider requested authorization for Nucynta 50mg # 60 one by mouth twice a day. Currently under review is the request for Nucynta 50mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nucynta 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 82-83. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter/Tapentadol (Nucynta).

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that on-going management and actions for opioid use 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 nonadherent) 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 nonopioid 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. Guidelines also recommend changing one drug

at a time. Official Disability Guidelines recommended Tapentadol (Nucynta) only as second line therapy for patients who develop intolerable adverse effects with first line opioids. In this case, there was no discussion of an opioid contract between the injured worker and provider. Urine drug screens had not been discussed or provided. Although previous documentation noted that Gabapentin caused sedation, on 05/22/2015 the provider prescribed (Gabapentin) which is first line therapy for neuropathic pain. She was also prescribed Vicodin, an opioid. There was no discussion following that to indicate failure with the prescribed treatment of Gabapentin and Vicodin. There was no documentation that the injured worker developed intolerable adverse effects with first line opioids. The medical necessity for this request was not established. The requested treatment is not medically necessary.