

<b>Case Number:</b>	CM15-0163316		
<b>Date Assigned:</b>	08/31/2015	<b>Date of Injury:</b>	12/24/2003
<b>Decision Date:</b>	10/05/2015	<b>UR Denial Date:</b>	08/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2015

### 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: Texas, California  
 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 69-year-old female who sustained an industrial injury on 12-24-03. Her initial complaints and the nature of the injury are not available for review. The PR-2, dated 8-7-15, indicates diagnoses of chronic low back pain, L2-L3 laminectomy, partial facetectomy at L2-3, L3-4, and L4-5 on 11-13-09, discogenic low back pain with radicular features, EMG from 8-9-11 with an acute left S1 radiculopathy and chronic L4-5 radiculopathy, left hip pain, status-post fracture and surgical repair in 2003 and neuropathic pain in the left chest secondary to chest tube trauma, L2-3 and L3-4 fusion on 6-30-15, and abscess of psoas post lumbar fusion. Her complaints upon presentation to the office were of "aching pain across the low back". She also reported pain and numbness in the right thigh, as well as aching in the hips. She reported that she was receiving physical therapy at home, but is still having "significant pain". She has a history of diabetes and reports that the "hospital took her off" insulin. She was inquiring about her blood sugars. Her appetite was noted to be poor and she complained of having abdominal pain. She also reported "significant constipation". She reported that she had not moved her bowels in approximately one week. The treatment plan indicated that she continues to have pain, but that the medications were "significantly helpful". The injured worker also complained of constipation, which was the probable cause of her abdominal pain. Samples of Relistor were given, as well as a prescription. Due to her recent hospitalization for a postoperative abscess, blood work was noted to be "needed to see if the infection is gone". A CBC with differential, fasting chemistry panel, and hemoglobin A1C were ordered. The provider indicated that he "needs to see if she should go back on her insulin". The medication list includes Oxycontin,

Norco, Zocor, Zestril, Benadryl, Flexeril and Gabapentin. The patient has had history of heart disease and DM. The patient has had UDS on 6/12/15 that was consistent.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **LAB-CBC: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Routine Suggested Monitoring: page 70.

**Decision rationale:** Request: LAB-CBC: Per the cited guidelines, "Routine Suggested Monitoring: recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests)." The PR-2, dated 8-7-15, indicates diagnoses of chronic low back pain, L2-L3 laminectomy, partial facetectomy at L2-3, L3-4, and L4-5 on 11-13-09, discogenic low back pain with radicular features, EMG from 8-9-11 with an acute left S1 radiculopathy and chronic L4-5 radiculopathy, left hip pain, status-post fracture and surgical repair in 2003 and neuropathic pain in the left chest secondary to chest tube trauma, L2-3 and L3-4 fusion on 6-30-15, and abscess of psoas post lumbar fusion. She has a history of diabetes and reports that the "hospital took her off" insulin. Her appetite was noted to be poor and she complained of having abdominal pain. She also reported "significant constipation". She reported that she had not moved her bowels in approximately one week. Due to her recent hospitalization for a postoperative abscess, blood work was noted to be "needed to see if the infection is gone". The CBC would help to check for anemia. In the context of constipation in a older patient checking for anemia is medically appropriate and necessary. In addition, in the context of a recent infection a CBC would help to check the WBC count. If the WBC count was elevated it would indicate presence of ongoing infection. Therefore, the blood test / LAB-CBC are certified as medically necessary for this patient at this time.

#### **Lab: Fasting chem panel: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Routine Suggested Monitoring: page 70.

**Decision rationale:** Lab: Fasting chem panel: Per the cited guidelines, "Routine Suggested Monitoring: recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests)." The PR-2, dated 8-7-15, indicates diagnoses of chronic low back pain, L2-L3 laminectomy, partial facetectomy at L2-3, L3-4, and L4-5 on 11-13-09, discogenic low back pain with radicular features, EMG from 8-9-11 with an acute left S1 radiculopathy and

chronic L4-5 radiculopathy, left hip pain, status-post fracture and surgical repair in 2003 and neuropathic pain in the left chest secondary to chest tube trauma, L2-3 and L3-4 fusion on 6-30-15, and abscess of psoas post lumbar fusion. She has a history of diabetes and reports that the "hospital took her off" insulin. Her appetite was noted to be poor and she complained of having abdominal pain. She also reported "significant constipation". She reported that she had not moved her bowels in approximately one week. The medication list includes Oxycontin, Norco, Zocor, Zestril, Benadryl, Flexeril and Gabapentin. The medication Norco contains Acetaminophen that can have adverse effects on the liver. The patient has had history of heart disease and DM. Long standing diabetes can affect the kidney. The fasting chem panel includes liver and kidney function tests as well as glucose levels. Therefore, the blood tests including Lab: Fasting chem panel are certified as medically necessary for this patient at this time.

**Relistor 12mg/0.6ml #15:** 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), Pain (Chronic): Opioid-induced constipation treatment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (updated 09/08/15) Methylalntrexone (Relistor®)Opioid-induced constipation treatment.

**Decision rationale:** Relistor 12mg/0.6ml #15: Relistor is indicated for the treatment of opioid-induced constipation in adult patients with advanced illness who are receiving palliative care, when response to laxative therapy has not been sufficient. As per the cited guideline "Methylalntrexone (Relistor) :Recommended only as a possible second-line treatment for opioid- induced constipation. See Opioid-induced constipation treatment." "First-line: When prescribing an opioid, and especially if it will be needed for more than a few days, there should be an open discussion with the patient that this medication may be constipating, and the first steps should be identified to correct this. Simple treatments include increasing physical activity, maintaining appropriate hydration by drinking enough water, and advising the patient to follow a proper diet, rich in fiber. These can reduce the chance and severity of opioid-induced constipation and constipation in general. In addition, some laxatives may help to stimulate gastric motility. Other over-the-counter medications can help loosen otherwise hard stools, add bulk, and increase water content of the stool. Second-line: If the first-line treatments do not work, there are other second- line options. About 20% of patients on opioids develop constipation, and some of the traditional constipation medications do not work as well with these patients, because the problem is not from the gastrointestinal tract but from the central nervous system, so treating these patients is different from treating a traditional patient with constipation. An oral formulation of methylalntrexone (Relistor) met the primary and key secondary end points in a study that examined its effectiveness in relieving constipation related to opioid use for non-cancer-related pain." Evidence of failure of first line treatment of constipation was not specified in the records specified. Evidence of failure of Simple treatments including increasing physical activity, maintaining appropriate hydration by drinking enough water, and advising the patient to follow a proper diet, rich in fiber was not specified in the records specified. The medical necessity of the request for Relistor 12mg/0.6ml #15 is not medically necessary for this patient.