

Case Number:	CM15-0245144		
Date Assigned:	12/24/2015	Date of Injury:	04/20/1999
Decision Date:	01/29/2016	UR Denial Date:	12/04/2015
Priority:	Standard	Application Received:	12/16/2015

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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 64 year old female, who sustained an industrial injury on 4-20-1999. The injured worker is undergoing treatment for: lumbar sprain and strain, shoulder joint pain, cervical and lumbar spondylosis. The treatment and diagnostic testing to date has included: medications, cervical facet block (4-23-14), MBB (8-6-14), radiofrequency neurotomy (10-16-14, 12-9-14), cervical surgery (2004, 2006, 2010), right shoulder surgeries (2001, 2005, 2012), CURES (6-10-15) noted as appropriate. Medications have included: oxycontin, oxycodone, flector patches, amitriptyline, ibuprofen, lansoprazole, Lidoderm patches, Colace, Tizanidine. Current work status: not documented. On 11-25-15, she reported continued neck and back pain. She indicated she had 'increased her stool softener to 4 per day which helped, but she still has issues'. The provider noted she had tried Amitiza, however could not recall the results of this medication and has continued constipation. She is noted to have a healed rectal prolapse. She also reported having to strain with bowel movements. Objective findings revealed her abdomen was 'not distended', no difficulty with rising from a seated position, non-antalgic gait. The treatment plan included trial of Movantik 25mg every day, quantity 30. The provider noted that miralax had been denied; and over the counter laxatives, stool softeners and Amitiza had failed. A prescription for Colace was refilled. The request for authorization is for: Movantik 25mg 30 count bottle. The UR dated 12-4-2015: non-certified the request for Movantik 25mg 30 count bottle.

IMR ISSUES, DECISIONS AND RATIONALES

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

Movantik 25mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter/Opioid-Induced Constipation Treatment Section and Other Medical Treatment Guidelines <https://www.movantikhcp.com/>.

Decision rationale: Per MTUS Guidelines, prophylactic treatment of constipation should be initiated when starting opioid treatment. Per the ODG, opioid induced constipation treatment is recommended as indicated below. In the section, Opioids, criteria for use, if prescribing opioids has been determined to be appropriate, then ODG recommends, under Initiating Therapy, that Prophylactic treatment of constipation should be initiated. Opioid-induced constipation is a common adverse effect of long-term opioid use because the binding of opioids to peripheral opioid receptors in the gastrointestinal (GI) tract results in absorption of electrolytes, such as chloride, with a subsequent reduction in small intestinal fluid. Activation of enteric opioid receptors also results in abnormal GI motility. Constipation occurs commonly in patients receiving opioids and can be severe enough to cause discontinuation of therapy. 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 don't 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 methylnaltrexone (Relistor) met the primary and key secondary end points in a study that examined its effectiveness in relieving constipation related to opioid use for noncancer-related pain. The effectiveness of oral methylnaltrexone in this study was comparable to that reported in clinical studies of subcutaneous methylnaltrexone in subjects with chronic noncancer-related pain. There was an 80% improvement in response with the 450 mg dose and a 55% improvement with 300 mg. Constipation drug lubiprostone (Amitiza) shows efficacy and tolerability in treating opioid-induced constipation without affecting patients' analgesic response to the pain medications. Lubiprostone is a locally acting chloride channel activator that has a distinctive mechanism that counteracts the constipation associated with opioids without interfering with the opiates binding to their target receptors. Per manufacturer information, Movantik is indicated for the treatment of opioid induced constipation. In this case, a progress report from 11-25-15 noted that the injured worker's stool softener was increased to 4 per day which helped, but she stated that she still has issues. The provider noted she had tried Amitiza, however could not recall the results of this medication and has continued constipation. She is noted to have a healed rectal prolapse. She also reported having to strain with bowel movements.

It appears that a trial of Mavantik is warranted in this case. The request for Movantik 25mg #30 is medically necessary.