

Case Number:	CM14-0213726		
Date Assigned:	02/05/2015	Date of Injury:	09/25/1991
Decision Date:	03/25/2015	UR Denial Date:	12/13/2014
Priority:	Standard	Application Received:	12/22/2014

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. 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, Tennessee

Certification(s)/Specialty: Emergency 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:

This 59-year-old male sustained a work-related neck and back injury on 9/25/1991. According to the progress notes dated 12/1/2014, the injured worker's (IW) diagnoses include cervical disc degeneration, s/p C7-T1 fusion, lumbosacral disc degeneration and carpal tunnel syndrome. He reports chronic neck and shoulder pain, numbness to the hands with occasional muscle twitching and low back pain with radiation to the right leg with numbness. Previous treatments include medications, TENS and surgery. The treating provider requests one prescription of Oxycontin 15 mg, #60; one prescription of Oxycodone IR 5mg, #90 and Amitiza 24 mcg, #60 with three refills. The Utilization Review on 12/13/2014 non-certified one prescription of Oxycontin 15 mg, #60 and one prescription of Oxycodone IR 5mg, #90; the request for Amitiza 24 mcg, #60 was modified to one refill only. Sources cited were CA MTUS Chronic Pain Medical Treatment guidelines and Official Disability Guidelines (ODG).

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 15mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 11, 74-96.

Decision rationale: Oxycontin is an extended release preparation of the opioid oxycodone. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDS have failed. In this case the patient has been using opioid medications since at least July 2012 and has not obtained analgesia. Criteria for long-term opioid use have not been met. The request should not be authorized.

Oxycodone IR 5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96.

Decision rationale: Oxycontin IR is an immediate release preparation of the opioid oxycodone. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDS have failed. In this case the patient has been using opioid medications since at least July 2012 and has not obtained analgesia. Criteria for long-term opioid use have not been met. The request should not be authorized.

Amitiza 24mcg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Opioid-induced constipation treatment

Decision rationale: Amitiza is the laxative lubiprostone. 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. If prescribing opioids has been determined to be appropriate, then ODG recommend that prophylactic treatment of constipation should be initiated.

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. Second line options include methylnaltrexone and lubiprostone. In this case the patient has been treated with Amitiza for severe constipation secondary to opioid medication since at least July 2012. Amitiza is not medically necessary unless the patient is taking opioid medication. Criteria for long-term opioid use have not been met. Amitiza is not medically necessary and should not be authorized.