

Case Number:	CM14-0216754		
Date Assigned:	01/26/2015	Date of Injury:	01/30/2002
Decision Date:	02/28/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/26/2014

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: Ohio, North Carolina, Virginia
 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 62-year old male with a date of injury of 1/30/2002. The mechanism of injury is not given . The diagnoses include T12 compression fracture, lumbar sprain, lumbar degenerative disc disease, depression, and anxiety. The injured worker complains of pain in the lower back, upper back, neck, left shoulder, and both hips. The physical exam has revealed diffuse tenderness to the cervical, thoracic, and lumbar spines. There is diminished range of motion. The upper and lower extremity reflexes are normal. Medications have included anti-depressants, motrin, Norco 10/325 mg, and colace 100 mg twice daily. He has had epidural steroid injections which have helped 50% and has had aquatherapy. At issue is a request for Norco 10/325 mg #30 and colace 100 mg #60. The Norco was non-certified as a result of no functional improvement being documented. Modified quantities have been certified to allow for weaning.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Patients prescribed opioids like Norco chronically should have ongoing assessment for pain relief, functionality, medication side effects, and any aberrant drug taking behavior. Opioids may generally be continued if there is improvement in pain and functionality and/or the injured worker has re-gained employment. In this instance, there is no evidence that the opioids are helping with the pain as pain levels have remained more or less constant. Documentation regarding functional status, past and present, is lacking. The appropriateness for continuing opioids is lacking justification. Therefore, Norco 10/325mg, #30 is not medically necessary.

Colace 100mg, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS.
Decision based on Non-MTUS Citation Pain (Chronic)

Decision rationale: 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. In this instance, the continued use of opioids has been found to be not medically necessary. The reason for current use of colace (stool softener) is not specified and no subjective entries regarding constipation are found fro the submitted medical record. Therefore, it is presumed the colace had been used to prevent and not to treat constipation. Hence, Colace 100mg, #60 is not medically necessary.