Case Number:	CM15-0205035		
Date Assigned:	10/21/2015	**Date of Injury:**	07/03/1985
Decision Date:	12/07/2015	**UR Denial Date:**	09/20/2015
Priority:	Standard	**Application Received:**	10/19/2015

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: 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 an 80 year old male, who sustained an industrial injury on 7-3-1985. The injured worker was being treated for chronic asthmatic bronchitis, allergic asthma, extrinsic asthma with frequent exacerbations, allergic rhinitis and chronic rhinitis. The injured worker reported (8-25-2015) feeling 90-100% better. The injured worker reported having completed the prednisone taper on 8-11-2015 and his wearing the SMART vest daily since the last visit. There was no documented physical exam on 8-25-2015. The medical records (8-25-2015) show the injured worker was administered Xolair subcutaneously and a Budesonide and Atrovent inhalation treatment in the treating physician office, with improved spirometry following the treatment. The treating physician (9-23-2015) noted the injured worker was short of breath on arrival. The injured worker reported using his oxygen machine as a bronchodilator nebulizer 1-4 times a day for as long as it takes to feel better. The injured worker reported being compliant with his medications. The physical exam (9-23-2015) reveals normal respiratory effort with wheezing in the bilateral lung fields. The medical records (9-23-2015) show the injured worker was administered Xolair subcutaneously and a Budesonide and Atrovent inhalation treatment in the treating physician office, with improved spirometry following the treatment. The pulmonary function test (5-20-2015) stated there was moderate obstructive pulmonary impairment. Per the treating physician (undated report), the injured worker has had frequent exacerbations that required the tapering of oral steroids from 3-10-2015 to 8-11-2015. Treatment has included bronchodilator nebulizers, home oxygen, a SMART vest, and medications including Montelukast at least 1-2015, oral prednisone, theophylline, Daliresp, an epinephrine pen, and Spiriva and

Proair inhalers. The treatment plan included continuing Montelukast. On 9-3-2015, the requested treatments included a one-year supply of Ipratropium 0.5mg/2ml and 10mg #90 with 3 refills. On 9-20-2015, the original utilization review non-certified requests for a one-year supply of Ipratropium 0.5mg/2ml and Montelukast 10mg #90 with 3 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

One year supply of Ipratropium 0.5mg/2ml: 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), Pulmonary (Acute & Chronic): Asthma medications (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pulmonary Chapter (Acute and Chronic): Asthma Medications and Chronic Bronchitis.

Decision rationale: Based on ODG guidelines, asthma treatment recommends a stepwise approach below. Inhaled corticosteroids (ICSs) are the most effective long-term control therapy. When choosing among treatment options, consider domain of relevance to the patient (impairment, risk or both), patient's history of response to the medication, and patient's willingness and ability to use the medication. (Demeter, 2011) According to the very widely recognized GINA (Global Initiative for Asthma) guidelines, the treatment of occupational asthma is identical to other forms of this condition. Therefore, when considering which medications are appropriate for treatment of occupational asthma, the GINA guidelines as well as a number of other guidelines were reviewed. (O'Lenic, 2012) Stepwise approach for managing asthma: Intermittent Asthma: SABA prn Persistent Asthma: Mild:- First-line: Low-dose ICS- Second-line: LTRA or Theophylline Persistent Asthma: Moderate:- First-line: Low-dose ICS + LABA OR Medium-dose ICS- Second-line: Medium-dose ICS + LABA- Third-line: Low-dose ICS + either LTRA or Theophylline - Fourth-line: Medium-dose ICS + either LTRA or Theophylline Persistent Asthma: Severe: First-line: High-dose ICS + LABA and Consider Anti- IgE for patients who have allergies - Second-line: High-dose ICS + LABA + Oral corticosteroids And Consider Anti-IgEKEY DRUG CLASS & DRUG NAMES: SABA = inhaled short-acting beta2-agonists: Albuterol (Ventolin); Levalbuterol (Xopenex); Pirbuterol (Maxair) - ICS = inhaled corticosteroids: Budesonide (Pulmicort); Fluticasone (Flovent) - LABA = inhaled long- acting beta2-agonists: Formoterol (Foradil); Salmeterol (Serevent) - LTRA = leukotriene receptor antagonists: Montelukast (Singulair); Zafirlukast (Accolate) - Anti-IgE = anti- immunoglobulin E therapy: Omalizumab (Xolair) - Theophyllines: Slo-Bid; Uniphyl- Oral corticosteroids: Prednisone (Deltasone); Prednisolone (Pediapred) - Combinations LABA/ICS: Advair (Salmeterol/Fluticasone); Combivent (Albuterol/Ipratropium, an anticholinergic); Symbicort (Formoterol/Budesonide). In the treatment of chronic bronchitis, the most effective way to reduce or eliminate cough in patients with chronic bronchitis and persistent exposure to respiratory irritants, such as personal tobacco use, passive smoke exposure, and workplace hazards is avoidance. Therapy with a short-acting inhaled agonist, inhaled ipratropium bromide, and oral theophylline or a combined regimen of inhaled long-acting agonist and an inhaled corticosteroid may improve cough in patients with chronic bronchitis, but there is no proven

benefit for the use of prophylactic antibiotics, oral corticosteroids, expectorants, postural drainage, or chest physiotherapy. In this case, the patient is already on Spiriva and it has been certified to continue. Ipatropium is an anticholinergic as is Spiriva. There is no clear indication in this case for the use of both Spiriva and ipatropium. Therefore, based on ODG guidelines and the information in this case, the request for a one-year supply of Ipatropium 0.5mg/2ml is not medically necessary.

Montelukast 10mg #90 with 3 refills: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pulmonary (Acute & Chronic): Asthma medications (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pulmonary Chapter (Acute and Chronic): Asthma Medications and Chronic Bronchitis.

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drainage, or chest physiotherapy. In this case, the patient is diagnosed with Asthma and Leukotriene receptor antagonists (such as Montelukast) are recommended as second or third line treatment for Asthma. Therefore, based on ODG guidelines and the information in this case, the request for Montelukast 10mg #90 with 3 refills is medically necessary.