

<b>Case Number:</b>	CM15-0046136		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	01/12/2003
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	03/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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: District of Columbia, Virginia  
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 a 41 year old female, who sustained an industrial injury on 01/12/2003. She has reported having worsening asthma. The diagnoses have included moderately severe asthma; gastroesophageal reflux disorder; and status post right carpal tunnel release. Treatment to date has included medications. Medications have included Norco, Albuterol, Omeprazole, and Prednisone. A progress note from the treating physician, dated 02/09/2015, documented an evaluation with the injured worker. Currently, the injured worker complains of dry cough, shortness of breath, wheezing, and nocturnal dyspnea. Objective findings included expiratory wheezing; arterial oxygen saturation was 97% at rest on room air. The treatment plan included prescription medications for adequate control of asthma. Request is being made for Advair Diskus 500/50 mcg with 3 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Advair Diskus 500/50mcg with 3 refills:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://emedicine.medscape.com/article/296301-treatment>.

**Decision rationale:** MTUS and ACOEM do not address this medication. Alternate guidelines were sought. According to emedicine.com, "The pharmacologic treatment of asthma is based on stepwise therapy. Asthma medications should be added or deleted as the frequency and severity of the patient's symptoms change. Step 1 - Intermittent asthma. A controller medication is not indicated. The reliever medication is a short-acting beta-agonist (SABA) as needed for symptoms. Step 2 - Mild persistent asthma. The preferred controller medication is a low-dose inhaled corticosteroid. Alternatives include sodium cromolyn, nedocromil, or a leukotriene receptor antagonist (LTRA). [74] Step 3 - Moderate persistent asthma. The preferred controller medication is either a low-dose inhaled corticosteroid plus a long-acting beta-agonist (LABA) (combination medication preferred choice to improve compliance) [75] or an inhaled medium-dose corticosteroid. Alternatives include an inhaled low-dose ICS plus either a leukotriene receptor antagonist, theophylline, or zileuton (Zyflo). Step 4 - Moderate-to-severe persistent asthma. The preferred controller medication is an inhaled medium-dose corticosteroid plus a leukotriene receptor antagonist (combination therapy). Alternatives include an inhaled medium-dose corticosteroid plus either a leukotriene receptor antagonist, theophylline, or zileuton. Step 5 - Severe persistent asthma. The preferred controller medication is an inhaled high-dose corticosteroid plus a leukotriene receptor antagonist. Consider omalizumab for patients who have allergies. Step 6 - Severe persistent asthma. The preferred controller medication is a high-dose inhaled corticosteroid plus a leukotriene receptor antagonist plus an oral corticosteroid. Consider omalizumab for patients who have allergies. Quick relief medication can be used for all patients and severities listed above. A short-acting beta agonist, as needed for symptoms, can be used. The intensity of treatment depends on the severity of symptoms. Up to 3 treatments at 20-minute intervals as needed can be administered. A short course of oral systemic corticosteroids may be needed. The use of a short-acting beta agonist more than 2 days a week for symptom relief (not prevention of exercise-induced bronchospasm) generally indicates inadequate control and the need to step up treatment. The 2009 VA/DoD guideline emphasizes that patients with persistent asthma should never be treated exclusively with long-acting beta2 agonists. [44] In patients with exercise-induced bronchospasm, the primary aim of therapy is prophylaxis to prevent acute episodes. A warm-up period of 15 minutes is recommended prior to a scheduled exercise event and has been shown to have a duration of effect as long as 40 minutes. This approach is not helpful for unscheduled events, prolonged exercise, or elite athletes. With exercise-induced bronchospasm, one of the primary treatments is to ensure good control of the underlying asthma. Regularly scheduled medications are generally not indicated for persons with isolated exercise-induced bronchospasm without underlying asthma. Prophylaxis in the form of inhaled medications administered 15-30 minutes prior to exercise is usually required. The most commonly used medications are short-acting beta agonists such as albuterol. Sodium cromolyn and nedocromil used 30 minutes prior to exercise have also been effective. The use of long-acting beta agonists such as salmeterol (at least 90 min before exercise) can be effective for repetitive exercise. Newer agents such as the leukotriene antagonists, inhaled heparin, and inhaled furosemide have demonstrated an ability to prevent exercise-induced bronchospasm. Inhaled corticosteroids have a limited role in the treatment of exercise-induced bronchospasm, except to control underlying asthma." Per review of the clinical data provided, the patient had persistent symptoms which did not improve with a short acting inhaler. This medication would be indicated. Therefore, this request is medically necessary.