

<b>Case Number:</b>	CM15-0051764		
<b>Date Assigned:</b>	03/25/2015	<b>Date of Injury:</b>	03/05/2004
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2015

### 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: North Carolina, Georgia  
 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 49-year-old female, who sustained an industrial injury on 03/05/2004. Initial complaints reported included low back and buttock pain resulting from a fall. The injured worker was diagnosed as having sacroiliac and lumbosacral strain/sprain. Treatment to date has included conservative care, medications, physical therapy, chiropractic manipulation, MRI of the lumbar spine, x-rays, and injections to the lumbar spine. Currently, the injured worker complains of low back pain radiating to the left lower extremity with associated numbness in the left lower extremity, and muscle spasms in the low back. It was noted that the injured worker experienced good overall improvement (reduction in pain, pain medication requirements, improved sleep, and improvement in ability to perform activities of daily living) from the epidural steroid injections to the lumbar spine. Current diagnoses include chronic pain, lumbar facet arthropathy and lumbar radiculitis. The treatment plan consisted of continued medications, continued home exercise program, and follow-up.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro: Naloxone 0.4mg/ml Syringe Evzio emergency kit (dos: 01/12/15), Qty: 1.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 27. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Naloxone.

**Decision rationale:** ODG section on Pain and Naloxone use lists the following consensus criteria for use of Naloxone. Criteria for prescriptions for naloxone for patients receiving opioids for pain in clinical settings for potential pre-hospital rescue (consensus based): (1) There should be documentation of a complete history that includes questions about prior drug and alcohol use (including previous overdose), recent detoxification or abstinence from drugs (for any reason), results of a screening tool for potential prescription drug abuse (such as the SOAPP-R), a complete list of chronic medical illnesses, and a complete medication list. See Opioids, screening tests for risk of addiction & misuse. (2) There should be evidence that education has been provided to the patient, with encouragement that family members and/or friends participate in this. Suggested education should include information about how to administer naloxone with practice with a training device if available. Other suggested components of training should include education on opioid overdose prevention, recognition of overdose and response to the event in addition to naloxone administration. Information on how to seek help from emergency medical systems should be made available and include an emphasis on staying with the patient until help arrives. (3) There should be evidence that the patient has been counseled about drug use including risk of self-escalation of doses, and self-monitoring of function. Patients should be advised to keep meds secure and to not share them. (4) There should be evidence that the patient has been given information about the risk of overdose, including risk factors for such (see the list above). (5) It is recommended that before prescribing, clinicians become knowledgeable about their states laws in terms of third-party prescribing, prescription via standing order, and Good Samaritan laws. This is, in part, as family members, friends, or other members of the community may be involved in the use of the drug for rescue. For additional information, the following can be accessed: (a) Legal Interventions to Reduce Overdose Mortality; Naloxone Access and Overdose Good Samaritan Laws; Available at: [https://www.networkforphl.org/\\_asset/qz5pvn/network-naloxone-10-4.pdf](https://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf). (b) Overview of State Legislation to Increase Access to Treatment for Opioid Overdose. NASADAD, 2013. Available at: <http://attcnetwork.org/userfiles/file/MidAmerica/Opioid-Overdose-Policy-Brief-Final6.pdf>. (6) A generic formulation is recommended as first-line treatment. Branded products such as Evzio & #130; are only recommended if generic is not available. Consideration for use should occur in the following situations: (1) Patients with the following problems who require opioids for legitimate medical reasons (who generally are treated for acute pain or palliative care/malignancy in a workers compensation setting): active abusers of scheduled drugs including opioids or those patients with a history of substance abuse; dependence or non-medical use of prescription or illicit drugs; patients recently discharged from emergency medical care following opioid intoxication; those who have been abstinent from opioids for a period due to detoxification including due to incarceration (due to possible reduced opioid tolerance and high risk of relapse to opioid use). (2) Patients on methadone or buprenorphine maintenance. (3) Patients who have had their opioids rotated (particularly to methadone) and may be at risk for incomplete tolerance. (4) The patient is prescribed high doses of opioids (100 mg of oral morphine equivalents as per current ODG

Guidelines) and tapering to less than this value or below is not practical or contraindicated. Particular consideration of naloxone prescribing should be given if (a) the patient is on concomitant benzodiazepines, sedative hypnotics (such as sleep aids), antidepressants, or muscle relaxants, (b) the patient has a history of pulmonary disease including chronic obstructive pulmonary disease, emphysema, asthma, and/or sleep apnea, (c) the patient has a history of liver and/or kidney disease, and/or (d) the patient has a history of mental illness. (5) The patient lives remotely from emergency care and is on high dose opioids. (6) The patient voluntarily requests naloxone. Considerations once prescribed: (1) Only one kit should be dispensed at any time. (2) Renewal should be by prescription based on medication expiration or damage. If the kit has been used, information should be provided as to why, and further treatment given as indicated based on this. See Opioids, dealing with misuse & In this case, although there is not a history of abuse, the provider has documented a conversation with the claimant about risks of opioid overdose and has instructed her to discuss the same and the use of a naloxone emergency kit with her family. She has requested a kit. However, the request is for the brand name Evzio kit which is not recommended as first line treatment. The Evzio naloxone kit is not medically necessary.