

Case Number:	CM15-0061068		
Date Assigned:	04/07/2015	Date of Injury:	04/24/2005
Decision Date:	05/21/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	03/31/2015

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: Texas, California
 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:

This is a 54-year-old female patient, who sustained an industrial injury on 4/24/2005. The diagnoses include other chronic pain, cervical disc displacement, cervical radiculopathy, and right shoulder pain. She sustained the injury when she picked up a case of water. Per the doctor's note dated 2/10/2015, she had complains of neck pain, radiating to the right shoulder and hand, accompanied by frequent tingling; low back pain with radiation to the right lower extremity. Pain was rated 1/10 with medications and 8/10 without. It was documented that she was only taking over the counter medications. She was currently not working. The physical examination revealed cervical spine- tenderness, trigger points, limited range of motion and decreased sensation in right C6 dermatome; tenderness at right AC joint, decreased right shoulder range of motion and decreased grip strength on the right side. The medications list includes naproxen, gabapentin, hydrocodone, naloxone and lisinopril. The use of Hydrocodone was noted since at least 10/2014. She has had Magnetic resonance imaging of the cervical spine on 11/24/2009 which revealed multi level disc changes. She had undergone cervical epidural corticosteroid injection on 10/21/2014. She has had urine drug screen on 10/7/14 and 3/19/15. The treatment plan included magnetic resonance imaging of the right shoulder and a renewal of current medications, including Hydrocodone, and a prescription for Naloxone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient MRI of right shoulder without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

Decision rationale: Outpatient MRI of right shoulder without contrast. According to ACOEM guidelines cited below, for most patients, special studies are not needed unless a three or four week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red flag conditions are ruled out. Criteria for ordering imaging studies are: Emergence of a red flag; e.g., indications of intra abdominal or cardiac problems presenting as shoulder problems; Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Reynaud's phenomenon); Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). "Physiologic evidence of significant tissue insult or neurovascular dysfunction is not specified in the records provided. Per the records provided, patient does not have any evidence of red flag signs such as possible fracture, infection, tumor or possible cervical cord compromise. The records provided did not indicate that surgical interventions were being considered. Response to a full course of conservative therapy including physical therapy for the right shoulder is not specified in the records provided. A recent right shoulder X-ray report is also not specified in the records provided. The medical necessity of Outpatient MRI of right shoulder without contrast is not established for this patient.

Hydrocodone 10-325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-80.

Decision rationale: Hydrocodone 10-325mg #60 Hydrocodone is an opioid analgesic. According to the cited guidelines, a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. The records provided do not specify that that patient has set goals regarding the use of opioid analgesic. The treatment failure with non-opioid analgesics is not specified in the records provided. Other criteria for ongoing management of opioids are: The lowest possible dose should be prescribed to improve pain and function. Continuing review of overall situation with regard to non-opioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Consider the use of a urine drug screen to

assess for the use or the presence of illegal drugs. The records provided do not provide a documentation of response in regards to pain control and objective functional improvement to opioid analgesic for this patient. The continued review of the overall situation with regard to non-opioid means of pain control is not documented in the records provided. As recommended by the cited guidelines a documentation of pain relief, functional status, appropriate medication use, and side effects should be maintained for ongoing management of opioid analgesic, these are not specified in the records provided. Response to antidepressant or lower potency opioid for chronic pain is not specified in the records provided. This patient does not meet criteria for ongoing continued use of opioids analgesic. The medical necessity of Hydrocodone 10-325mg #60 is not established for this patient.

Naloxone 0.4mg/0.4mg syringe evzio emergency kit number one (#1): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page Number 27, 75, 100. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Pain (updated 04/30/15) Evzio (naloxone) Naloxone (Narcan ½).

Decision rationale: Request: Naloxone 0.4mg/0.4mg syringe evzio emergency kit number one (#1) Naloxone hydrochloride injection is indicated for the complete or partial reversal of narcotic depression, including respiratory depression, induced by opioids. According to CA MTUS guidelines cited above Opioid antagonists such as naloxone are most often used to reverse the effects of agonists and agonist-antagonist derived opioids. Per the cited guidelines Evzio is an FDA-approved naloxone drug-device combination indicated for the emergency treatment of opioid overdose. The device is designed to guide an untrained lay user through the process of use for overdose reversal. It is labeled for prehospital lay use. It does not require pre use training nor does it require assembly (as required for existing intramuscular or off-label intranasal use). (Beletsky, 2015) See Naloxone (Narcan) for complete information. 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). (6) A generic formulation is recommended as first-line treatment. Branded products such as Evzio 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 worker's 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). (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. History of previous drug/alcohol over dose, recent detoxification is not specified in the records provided. History of substance abuse is not specified in the records provided. History of the patient taking a high dose of opioids is not specified in the records provided. The medical necessity of Naloxone 0.4mg/0.4mg syringe evzio emergency kit number one (#1) is not fully established in this patient.