

Case Number:	CM15-0069575		
Date Assigned:	04/17/2015	Date of Injury:	08/21/2008
Decision Date:	06/11/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/13/2015

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: 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 54 year old female who sustained an industrial injury on 8/21/08. The injured worker reported symptoms in the neck, back, upper and lower extremities. The injured worker was diagnosed as having chronic pain, lumbar radiculopathy and severe left knee osteoarthritis. Treatments to date have included acupuncture treatment, myofascial release, oral pain medication, and epidural steroid injection. Currently, the injured worker complains of pain in the neck, back, upper and lower extremities. The plan of care was for therapy, epidural steroid injection and a follow up appointment at a later date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic therapy 2 x 4, lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy, Physical Medicine Guidelines Page(s): 22, 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

Decision rationale: The MTUS/Chronic Pain Medical Treatment guidelines comment on the use of aquatic therapy as a treatment modality. Aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. In this case, the records indicate that the patient has already undergone a course of physical therapy for the lumbar spine. It would be expected that the patient has been now able to assume a self-directed home exercise program. There is insufficient documentation to support the rationale for a water-based program. Given the lack of documentation of effect of physical therapy, the lack of documentation of the outcomes of a self-directed home exercise program and the lack of justification for the need for an aquatic therapy program, aquatic therapy 2 times a week for 4 weeks is not considered as medically necessary.

Bilateral L5-S1 transformational epidural steroid injection under fluoroscopy: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: The MTUS/Chronic Pain Medical Treatment guidelines provide the criteria for the use of Epidural steroid injections. These criteria are as follows: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In this case the records indicate that the patient has an underlying radiculopathy as the primary source of the lumbar pain syndrome. This is well-documented in the medical records. Further, the patient had a clinically significant response to a prior ESI for the same reason. Specifically, the patient received an lumbar ESI on 10/2013 and had a 50-80% response in pain relief from this intervention. There is no evidence that the patient does not meet these above cited MTUS criteria for a repeat injection. Under these conditions, the records support the MTUS recommendations for a bilateral L5-S1 epidural steroid injection. This treatment is considered as medically necessary.

Evzio emergency kit #1: 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) Pain Naloxone (Narcan).

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

Decision rationale: The Official Disability Guidelines comment on the 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. (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. (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 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). (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. Based on my review of the available records, the documentation does not meet the above cited criteria to establish the need for an Evzio emergency kit. This includes lack of documentation of prior incidents of an opioid overdose, education provided to family and friends, attempts to wean the patient from opioids, the lack of access to emergency services, the total opioid dose exceeding the MTUS requirements, and the request for brand name Naloxone instead of a generic version. For these reasons, Evzio is not considered as a medically necessary treatment.