

<b>Case Number:</b>	CM13-0047451		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	09/18/2003
<b>Decision Date:</b>	03/10/2014	<b>UR Denial Date:</b>	10/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/02/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 45-year-old female who reported an injury on 09/18/2003. The patient has had ongoing complaints of jaw and lower right lumbar region pain and had a fusion performed at the L3-4 level of her lumbar spine. Since the patient's procedure, she has continued to have lumbar spine pain and has undergone an epidural steroid injection that provided her with significant relief; whereupon, the patient stated that it was the best she had felt in 7 years. The patient had been taking several different oral medications, to include Ambien and Percocet, which helped to decrease the pain and improve her overall function. The patient was seen again on 10/09/2013 for the same complaints of jaw and lower right lumbar region pain. On the day of this examination, the patient stated that she was ready for a detoxification program and was planning on divesting herself of her medications. The patient stated that her sleep was improved as well as her mood, and she was taking her medications as prescribed. The patient still had pain symptoms on a continuous basis, but they were alleviated somewhat by current medications. On that date, the patient was noted to have been taking Percocet every 3 hours, which had decreased her pain level to a 3/10 to 4/10 instead of a 9/10 on the VAS. The patient also had been taking an extra 1/2 pill with her dose and was noted to have some medications leftover. The patient was most recently seen on 11/22/2013, which listed her major problems as major depressive affective disorder with recurrent episodes; anxiety state, unspecified; depressive disorder, not elsewhere classified; and lumbar postlaminectomy syndrome. The patient at that time was taking Ambien 10 mg, Percocet 10/325 mg and tizanidine 4 mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**outpatient detoxification program:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Detoxification Page(s): 42.

**Decision rationale:** Under the California MTUS Guidelines, it states that detoxification is defined as withdrawing a person from a specific psychoactive substance and does not imply a diagnosis of addiction, abuse or misuse. It may be necessary due to the following: (1) intolerable side effects, (2) lack of response, (3) aberrant drug behaviors as related to abuse and dependence, (4) refractory comorbid psychiatric illness or (5) lack of functional improvement. It further states that gradual weaning is recommended for long-time opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. In the case of this patient, she was utilizing Percocet on a more frequent basis of every 3 hours as needed for pain and also having prescriptions written to be filled roughly every other month. More recent documentation noted that the patient had reduced her Percocet use to every 4 to 6 hours instead of every 3 hours; however, the number of tablets being prescribed at 1 time is still fairly high at 180 tablets with each prescription. Because some of the documentation indicates that the patient was to stop utilizing the Percocet in 01/2014, and without having sufficient evidence that the patient has thoroughly began tapering down her medication use in regards to Percocet; the requested service for a detoxification program cannot be warranted. However, on that note, it is unclear as to why the patient would need an outside detoxification program when the prescribing physician could be assisting with her detoxification by simply tapering off the medication just by the number of tablets being prescribed on a monthly basis. Therefore, without having a thorough rationale beyond the necessity for an outpatient detox program, the requested service cannot be warranted and is non-certified.