

<b>Case Number:</b>	CM14-0078420		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	06/07/2008
<b>Decision Date:</b>	10/20/2014	<b>UR Denial Date:</b>	05/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/28/2014

### 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. The expert reviewer is Board Certified in Psychiatry and is licensed to practice in California. 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/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:

Injured worker is a 27 year old male with date of injury 6/7/2008. Date of the UR decision was 5/1/2014. Mechanism of injury was described as a fall at work, head first, in which he encountered multiple physical injuries. She developed chronic pain in neck, back, upper extremities and knees. Report dated 4/28/2014 indicated that there were 2 approved authorizations dated 3/24/2014, 4/23/2014 for 7 day inpatient detox program followed by 30 days of intensive outpatient detox therapy. However per that report a more extensive detox program was recommended to wean him off his opioid medications to further stabilize his abstinence and assist in pain stabilization and anxiety management. Report dated 3/24/2014 suggested that the medications prescribed by the provider at that visit were Ambien CR 12.5 mg as needed for insomnia, Celebrex 200 mg for inflammation, Fiorinal for headaches, Norco to be taken as needed for severe pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RUSH - 30 day residential treatment program:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Detoxification. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, detoxification section

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Mental & Stress>, < Hospital length of stay (LOS)

**Decision rationale:** ODG states "Hospital length of stay (LOS): Recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. Alcohol Rehab/Detox (icd 94.63 - Alcohol rehabilitation and detoxification) Actual data -- median 5 days; mean 7.0 days (1.1); discharges 12,586; charges (mean) \$12,166 Best practice target (no complications) -- 5 days". The request for RUSH - 30 day residential treatment program is excessive and not medically necessary per the guidelines. It has been suggested that the injured worker has been 3/24/2014, 4/23/2014 for 7 day inpatient detox program followed by 30 days of intensive outpatient detox therapy.

**3 month intensive outpatient program following 30 day residential treatment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Detoxification. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, detoxification section

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Mental & Stress < Cognitive therapy for opioid dependence

**Decision rationale:** ODG guidelines state "Cognitive therapy for opioid dependence is under study. The addition of cognitive behavioral therapy (CBT) to medical treatment for opioid dependence does not significantly enhance outcomes compared with medical treatment alone, according to this RCT which excluded patients with untreated psychiatric disorders as well as those who had addictions to other substances. (CBT may be beneficial to those patients.) 141 opioid-dependent patients were randomly assigned to physician management or physician management plus CBT. Physician management consisted of a brief visit, during which patients received the combination of buprenorphine/naloxone at a dose of 16 mg daily throughout the 24-week trial. The dose of buprenorphine could be increased to 20 to 24 mg a day, depending on the level of discomfort or on evidence of ongoing illicit opioid use. Patients receiving additional Cognitive-Behavioral Therapy (CBT) were treated with the same medication but were offered additional CBT in the form of up to 12 50-minute weekly sessions during the first 12 weeks of treatment. There was no change in outcomes. Both approaches resulted in a reduction in the mean self-reported frequency of opioid use from 5.3 days per week at baseline to 0.6 days during the first 12 weeks of the trial. This dropped to a mean of 0.4 days from weeks 12 to 24, when the combination group was no longer receiving CBT. A significant reduction in negative urine test results was also observed in both groups from the first 12 weeks of treatment to the second 12 weeks of treatment. The number of patients who needed to be transferred to methadone maintenance because of ongoing opioid use or for acute psychiatric decompensation also did not differ between the 2 treatment groups. Among primary care providers, there still may be a level of hesitancy to provide treatment for opioid dependence out of concern that they may not have the appropriate counseling skills, according to the authors, but this study shows that many can do without sophisticated psychosocial counseling". Report dated 4/28/2014 indicated that there were

2 approved authorizations dated 3/24/2014, 4/23/2014 for 7 day inpatient detox program followed by 30 days of intensive outpatient detox therapy. However per that report a more extensive detox program was recommended to wean him off his opioid medications to further stabilize his abstinence and assist in pain stabilization and anxiety management. The request for 3 month intensive outpatient program following 30 day residential treatment is excessive and not medically necessary per the guidelines. It has been suggested that the injured worker has been 3/24/2014, 4/23/2014 for 7 day inpatient detox program followed by 30 days of intensive outpatient detox therapy.