

Case Number:	CM15-0183937		
Date Assigned:	09/24/2015	Date of Injury:	11/28/2011
Decision Date:	10/30/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/18/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 34 year old female who sustained an industrial injury November 28, 2011, after a motor vehicle accident. Diagnoses was documented as chronic pain, other; lumbar facet arthropathy; lumbar radiculitis and depression. She has been followed by a psychiatrist. Past treatment included acupuncture and medication and she underwent x-rays. According to a qualified medical examiner's re-evaluation, the injured worker developed her first seizure July 4, 2014. A primary treating orthopedic surgeon's progress report dated July 13, 2015, the injured worker presented for follow-up evaluation. She had another seizure the previous evening and was transported and evaluated in an emergency room. She required stitches for a right forehead laceration with significant periorbital edema and ecchymosis. She reported she was changed from brand Klonopin to generic Clonazepam three days ago. She continues to utilize Keppra as prescribed. Authorization for a requested in-patient detox program with EEG (electro-encephalogram) monitoring at a hospital was obtained in February 2015 but they were unable to schedule the admission. Recently, the treating physician's office was able to speak to the director of the neuropsychological department and notified that no new patients were being accepted at this time. The injured worker is followed by neurology and psychiatry with plan to admit to another facility. She complains of worsening head pain rated 7 out of 10, neck, upper and lower back pain rated 8 out of 10, and bilateral hip and knee pain, rated 8 out of 10, since the seizure and subsequent fall. She completed a course of acupuncture, which provided a reduction in pain and increase in functional status (not described). Diagnoses are post-traumatic stress disorder; left shoulder impingement syndrome; chronic intractable pain syndrome; depression

and anxiety, seizure disorder; cervical, thoracic, lumbar strain. Treatment plan included recommendation and authorization for another facility for detox program. A follow-up neurology evaluation dated August 3, 2015, the physician documented changes since last seizure; provided a prescription for post-concussion headache of Tylenol #3, increased dosage of Keppra, follow-up with ear nose and throat physician for hearing deficit right ear, and be seen in a major medical center for further evaluation and assessment of exact location that generates seizure. A primary treating orthopedic physician's report dated August 17, 2015, finds the injured worker somewhat sedated due to an increase in the anti-epileptic medication. The pain previously described is still present and the physician recommends additional acupuncture, x-rays, and random urine toxicology screening. At issue, is the request for authorization for detox program, 7-10 days. According to utilization review dated September 1, 2015, the request for a Detox Program, 7-10 days is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Detox program 7 to 10 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

Decision rationale: The claimant sustained a work injury in November 2011 and is being treated for radiating neck pain, headaches, upper and mid back pain, and radiating low back pain. She has a seizure disorder possibly related to benzodiazepine withdrawal from Klonopin. When seen, she was having difficulty tolerating an increased dose of Keppra due to sedation. Pain was rated at 8/10. Flector was being prescribed. Physical examination findings included paravertebral muscle tenderness. Inpatient detox is being requested. Gradual weaning of benzodiazepine medication is recommended for long-term users. Requesting detoxification from benzodiazepine medication in a 10-day period of time is not appropriate. In this case, there is no evidence of a failure of outpatient medication weaning and the claimant does not even appear to be taking this medication anymore. The request is not medically necessary.