

Case Number:	CM15-0198256		
Date Assigned:	10/13/2015	Date of Injury:	02/01/1999
Decision Date:	11/20/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/08/2015

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 62 year old male, who sustained an industrial injury on 2-1-1999. The injured worker is undergoing treatment for status post cervical and lumbar spine surgery with residual symptoms, failed back syndrome, lower extremity radiculopathy and psychological sequelae. Medical records dated 7-16-2015 indicate the injured worker complains of neck pain and stiffness, persistent back pain radiating to the legs with numbness, tingling and weakness and anxiety, depression and sleep disturbance. Physical exam dated 8-24-2015 notes cervical and lumbar tenderness to palpation. Treatment to date has included Methadone, Klonopin and Soma. Supplemental report dated 8-24-2015 indicates the injured worker "has a 12-year history of Oxycontin." The original utilization review dated 9-30-2015 indicates the request for supervised detoxification program is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Supervised detoxification program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Detoxification.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Chronic pain programs, opioids, Detoxification, Weaning of Medications.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on measures to address detoxification from controlled substances. Detoxification is defined as withdrawing a person from a specific psychoactive substance, and it does not imply a diagnosis of addiction, abuse or misuse. 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. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. These MTUS guidelines also describe the criteria for use of an inpatient program. These programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who: (1) don't have the minimal functional capacity to participate effectively in an outpatient program; (2) have medical conditions that require more intensive oversight; (3) are receiving large amounts of medications necessitating medication weaning or detoxification; or (4) have complex medical or psychological diagnosis that benefit from more intensive observation and/or additional consultation during the rehabilitation process. Finally, the MTUS guidelines describe the process for weaning from controlled substances. For opioids, a slow taper is recommended. The longer the patient has taken opioids, the more difficult they are to taper. The process is more complicated with medical comorbidity, older age, female gender, and the use of multiple agents. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. Patients with complex conditions with multiple comorbidities (including psych disorders) should be referred to an addiction medicine/psychiatry specialist. Opioid weaning should include the following: (a) Start with a complete evaluation of treatment, comorbidity, psychological condition; (b) Clear written instructions should be given to the patient and family; (c) If the patient cannot tolerate the taper, refer to an expert (pain specialist, substance abuse specialist); (d) Taper by 20 to 50% per week of original dose for patients who are not addicted (the patient needs 20% of the previous day's dose to prevent withdrawal); (e) A slower suggested taper is 10% every 2 to 4 weeks, slowing to a reductions of 5% once a dose of 1/3 of the initial dose is reached; (f) Greater success may occur when the patient is switched to longer-acting opioids and then tapered; (g) Office visits should occur on a weekly basis; (h) Assess for withdrawal using a scale such as the Subjective Opioid Withdrawal Scale (SOWS) and Objective Opioid Withdrawal Scale (OOWS); & (i) Recognize that this may take months. Benzodiazepine: Tapering is required if used for greater than 2 weeks. This is more dangerous than opioid withdrawal, and takes more time, with the following recommendations: (1) The recommended rate of tapering is about 1/8 to 1/10 of the daily dose every 1 to 2 weeks; (2) Rate of withdrawal should be individually tapered; (3) Tapering may take as long as a year; (4) High-dose abusers or those with polydrug abuse may need in-patient detoxification; & (5) Withdrawal can occur when a chronic user switches to a benzodiazepine with a different receptor activity. (Lee, 2002) Carisoprodol (Soma): This medication is metabolized to meprobamate, a barbiturate. At the highest levels of barbiturate tolerance, the patient is at risk of delirium, seizures or even death with abrupt discontinuation. There is little research in terms of weaning of high dose carisoprodol and there is no standard treatment regimen for patients with known dependence. Most treatment includes treatment for symptomatic complaints of withdrawal. Another option is

to switch to phenobarbital to prevent withdrawal with subsequent tapering. A maximum dose of phenobarbital is 500 mg/day and the taper is 30 mg/day with a slower taper in an outpatient setting. Tapering should be individualized for each patient. In this case, there is insufficient information provided in the patient's medical records to justify the need for a supervised detoxification program. Further, it is not specified whether this implies an inpatient detoxification program as described above. There is insufficient documentation as to whether there have been efforts to assist the patient in engaging in a weaning program as described in the above cited MTUS guidelines. Further documentation on these issues will need to be completed to assess whether the patient is eligible for a detoxification program. For these reasons, a supervised detoxification program is not medically necessary at this time.