

Case Number:	CM15-0024652		
Date Assigned:	03/18/2015	Date of Injury:	04/18/2002
Decision Date:	04/20/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/09/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 44 year old female, who sustained an industrial injury on April 18, 2002. She reported shoulder, neck, and back injuries. The injured worker was diagnosed as having chronic pain syndrome, status post anterior cervical discectomy/fusion cervical 4-5, status post lumbar 4-5 laminectomy/discectomy, status post right shoulder surgery, and long history of opiate dependence. Treatment to date has included physical therapy, chiropractic therapy, psychotherapy, H-wave, home strengthening and stretching program, and antidepressant, anticonvulsant, oral and topical pain, anticonvulsant, and muscle relaxant medications. On January 5, 2015, the injured worker complains of diffuse neck, upper extremities, back, and bilateral thigh pain with burning in the feet. Her pain level is 7/10 with medications. She currently is taking two oral pain, one topical pain, anticonvulsant, and muscle relaxant medications. The treating physician notes that she has completed a course of cognitive behavior therapy, which resulted in her decreased use of pain medications. She has significantly decreased one of her pain medications. She has attended Narcotics Anonymous and decided she wants to get off the medications. The physical exam was unremarkable. The treatment plan includes requests for a detox program and a functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Detox program for 10 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Weaning of Medications. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Detoxification.

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

Decision rationale: According to MTUS guidelines, detoxification is recommended as indicated below. 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. (Benzon, 2005) See also Rapid detox. According to ODG guidelines, most commonly recommended when there is evidence of substance misuse or abuse, evidence that medication is not efficacious, or evidence of excessive complications related to use. See Substance abuse (substance related disorders, tolerance, dependence, addiction) for definitions. Detoxification is defined as a medical intervention that manages a patient through withdrawal syndromes. While the main indication as related to substance-related disorders is evidence of aberrant drug behaviors, other indications for detoxification have been suggested. These include the following: (1) Intolerable side effects; (2) Lack of response to current pain medication treatment (particularly when there is evidence of increasingly escalating doses of substances known for dependence); (3) Evidence of hyperalgesia; (4) Lack of functional improvement; and/or (5) Refractory comorbid psychiatric illness. It can therefore be seen that a recommendation for detoxification does not necessarily imply a diagnosis of addiction, or of substance-related disorder. There are no specific guidelines that have been developed for detoxification for patients with chronic pain. This intervention does not constitute complete substance abuse treatment. The process of detoxification includes evaluation, stabilization, and preparation of the patient for further treatment that should be specifically tailored to each patient's diagnostic needs. Complete withdrawal of all medications is not always recommended, although evidence of abuse and/or dependence strengthens the rationale for such. (TIP 45, 2006) (Wright, 2009) (Benzon, 2005) See also Weaning of medications; Rapid detox; Substance abuse (substance related disorders, tolerance, dependence, addiction) for definitions. For average hospital LOS if criteria are met, see Hospital length of stay (LOS Drug Detox (icd 94.65 Drug detoxification) Actual data median 4 days; mean 4.1 days (130;0.2); discharges 78,219; charges (mean) ██████ Best practice target (no complications) 4 days. In this case, the patient attended 6 sessions of CBT and was able to reduce her Norco intake and significantly reduce her Dilaudid. There is no clear documentation of intolerable side effects, aberrant behavior, drug abuse and dependence. Furthermore, there is no clear description of the detox program. Therefore, the request for Detox Program for 10 weeks is not medically necessary.

1 functional restoration program, 10 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs); Chronic pain programs (functional restoration programs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 31-33.

Decision rationale: Chronic pain programs (functional restoration programs); Recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria outlined below. Also called Multidisciplinary pain programs or Interdisciplinary rehabilitation programs, these pain rehabilitation programs combine multiple treatments, and at the least, include psychological care along with physical therapy & occupational therapy (including an active exercise component as opposed to passive modalities). While recommended, the research remains ongoing as to (1) what is considered the gold-standard content for treatment; (2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) (Patrick, 2004) (Buchner, 2006) Unfortunately, being a claimant may be a predictor of poor long-term outcomes. (Robinson, 2004) These treatment modalities are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. (Gatchel, 2005) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003) Types of treatment: Components suggested for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical treatment; (b) medical care and supervision; (c) psychological and behavioral care; (d) psychosocial care; (e) vocational rehabilitation and training; and (f) education. Predictors of success and failure: As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. (Gatchel, 2006) The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pretreatment levels of pain. (Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel, 2005) Multidisciplinary treatment strategies are effective for patients with chronic low back pain (CLBP) in all stages of chronicity and should not only be given to those with lower grades of CLBP, according to the results of a prospective longitudinal clinical study reported in the

December 15 issue of Spine. (Buchner, 2007) See also Chronic pain programs, early intervention; Chronic pain programs, intensity; Chronic pain programs, opioids; and Functional restoration programs. Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: 1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; (6) Negative predictors of success above have been addressed. There is no objective documentation that the patients failed previous methods for treating pain and have a significant loss of function. Therefore, the request is not medically necessary.

1 prescription of Soma 350mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma (carisoprodol).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma Page(s): 29.

Decision rationale: According to MTUS guidelines, non sedating muscle relaxants is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. According to the provided file, the patient was prescribed Soma for a long time without clear evidence of spasm or functional improvement. There is no justification for prolonged use of Soma. The request for Soma 350mg is not medically necessary.

1 prescription of Dilaudid 8mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydromorphone (Dilaudid).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

Decision rationale: According to MTUS guidelines, Dilaudid is a short acting opioids is seen an effective medication to control pain. Hydromorphone (Dilaudid; generic available): 2mg, 4mg, 8mg. Side Effects: Respiratory depression and apnea are of major concern. Patients may experience some circulatory depression, respiratory arrest, shock and cardiac arrest. The more common side effects are dizziness, sedation, nausea, vomiting, sweating, dry mouth and itching.

(Product Information, Abbott Labs 2006) Analgesic dose: Usual starting dose is 2mg to 4mg PO every 4 to 6 hours. A gradual increase may be required, if tolerance develops. According to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. There is no clear evidence and documentation from the patient file, for a need for more narcotic medications. There is no evidence of pain breakthrough. The patient reported that she was able to reduce Dilaudid use by self weaning and with the help of CBT sessions. Therefore, the prescription of Dilaudid 8mg is not medically necessary.