

<b>Case Number:</b>	CM13-0018136		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	09/08/2003
<b>Decision Date:</b>	01/16/2014	<b>UR Denial Date:</b>	07/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2013

### 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 Neurology, has a subspecialty in Neuro- Oncology and is licensed to practice in Massachusetts, Ohio and 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.

### 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 59-year-old female with a reported date of injury on 09/08/2003. The patient presented with numbness, tingling sensations, seizures, headaches, anxiety and back pain. The patient had no joint swelling, no joint stiffness, no weakness, no tremor, no unsteadiness and no speech difficulties. The patient was previously treated with Neurontin, Dilantin, Trileptal, Gabitril, Depakote, Zonergan and Lyrica. The patient previously underwent 2 normal MRI scans in 2003 and 2005 and an EMU study in 2005. The patient's diagnoses included partial complex seizure with secondary generalization with intractable seizure. The provider's treatment plan included a request for a prescription of levetiracetam 500 mg and 1 epilepsy monitoring unit between 05/06/2013 and 09/10/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Levetiracetam 500mg ( qty unknown ):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Institute for Health and Clinical Excellence (NICE). The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care. London (UK): National Institute for Health and Clinical Excellence (NICE); 2012 Jan.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs Page(s): 16-22. Decision based on Non-MTUS Citation MedlinePlus

**Decision rationale:** Levetiracetam may be effective for neuropathic pain. The ultimate role of these agents for pain requires further research and experience; in the interim, these agents should be used to treat neuropathic pain only when carbamazepine, gabapentin, or lamotrigine cannot be used. MedlinePlus notes that levetiracetam is used in combination with other medications to treat certain types of seizures in people with epilepsy. Levetiracetam is in a class of medications called anticonvulsants, and it works by decreasing abnormal excitement in the brain. The provider noted that Vimpat was discontinued due to financial reasons, which caused the patient to have more seizures, coming up to 2 or 3 events per day. Due to the seizures, Keppra 500 mg was then added, which was noted to not provide significant benefit. In addition, the patient believed that Keppra caused nausea and worsened her hair loss. Within the provided documentation, the efficacy of the medication was unclear. Therefore, the request for levetiracetam 500 mg is neither medically necessary nor appropriate.

**epilepsy monitoring unit between 5/6/2013 and 9/10/2013:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation theNational Institute for Health and Clinical Excellence (NICE). The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care. London (UK): National Institute for Health and Clinical Excellence (NICE); 2012 Jan

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Janice M. Buelowa, Michael Privitera, Paul Levisohn, Gregory L. Barkley, (2009). A description of current practice in epilepsy monitoring units. Epilepsy & Behavior, Volume 15, Issue 3, Pages 308-313

**Decision rationale:** The California MTUS Guidelines, ACOEM and the Official Disability Guidelines do not address. In the study authored by Buelowa et al., it is noted that in the epilepsy monitoring unit (EMU), a patient whose seizures may be under control is placed in a medication-withdrawal situation to induce seizures for direct observation and recording. This withdrawal introduces patient risk. In addition, because the EMU is a complex medical and restrictive physical environment, other risks are brought into play. Patient management to reduce danger while optimizing results should arise from current evidence, but gaps exist in the literature regarding best practice in the EMU. In this article, the authors report results of two national surveys of health care practitioners in specialized epilepsy care regarding current EMU practice. Within the provided documentation, it was unclear how long the inpatient stay was for. Additionally, the requesting physician's rationale for the request was unclear. The patient had undergone an EMU study in 2005. Therefore, the request 1 epilepsy monitoring unit between 05/06/2013 and 09/10/2013 is neither medically necessary nor appropriate.

