

<b>Case Number:</b>	CM13-0071055		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	10/16/2000
<b>Decision Date:</b>	06/27/2014	<b>UR Denial Date:</b>	12/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/26/2013

### 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 Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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:

The injured worker is a 51-year-old male who reported an injury on 10/16/00 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to his head, neck, back, and bilateral shoulders. The injured worker's treatment history included physical therapy, a back brace, surgical intervention of the shoulder, a TENS unit, an interferential current stimulation unit, psychological support, chiropractic care, lumbar fusion, and cervical fusion. The injured worker's chronic pain was managed with multiple medications. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker was evaluated on 10/21/13. It was documented that the injured worker had continued vertebral tenderness at the L4-S1 with decreased sensation of the bilateral lower extremities, specifically in the L4 through S1 dermatomal distribution. The injured worker's diagnoses included lumbar radiculopathy, cervical radiculopathy, status post cervical fusion, status post lumbar fusion, headaches, gastritis, depression, chronic pain, medication-related dyspepsia, status post three right shoulder surgeries, and a history of incontinence. The injured worker's treatment plan included continuation of aquatic therapy to assist with pain control and functional restoration and medication refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DEPAKOTE 500 MG # 120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.rxlist.com/depakote-drug/indications-dosage.htm>

**Decision rationale:** The California Medical Treatment Utilization Schedule and the Official Disability Guidelines do not address this medication. An online resource, Rxlist.com, indicates that this medication is for long-term use in the management of bipolar disorder, mania, epilepsy, and migraines. The clinical documentation submitted for review does not specifically identify a diagnosis that would support the use of this medication. Additionally, there are no physical or psychological findings to support continued use. The clinical documentation indicates that the injured worker has been on this medication since at least May 2013. However, without any objective functional improvement related to the use of this medication, and in the absence of symptoms that require management of this medication, continue use would not be supported. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined, and the request is not medically necessary.

**8 AQUATIC THERAPY SESSIONS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, 15, 400

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Aquatic Therapy Page(s): 22.

**Decision rationale:** The California Medical Treatment Utilization Schedule recommends aquatic therapy for injured workers who require a non-weight-bearing environment to participate in active therapy. The clinical documentation submitted for review does not provide any evidence that the injured worker requires a non-weight-bearing environment and would not be responsive to land-based physical therapy. Additionally, the clinical documentation indicates that the injured worker has previously participated in aquatic therapy. The efficacy of those sessions is not clearly indicated within the submitted documentation. Furthermore, the request as it is submitted does not clearly identify a body part. In the absence of this information the appropriateness of the request itself cannot be determined, and the request is not medically necessary.