MAXIMUS Federal Services

Case Number:	CM14-0019831		
Date Assigned:	04/28/2014	Date of Injury:	10/15/2010
Decision Date:	07/08/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	02/18/2014

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 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 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 61 year old male who reported an injury on 10/15/2010, due to a motor vehicle accident. The clinical note dated 09/18/2013 presented the injured worker with neck pain that radiated to his hands, weakness in the arms and hands, low back pain that radiated to the bilateral lower extremities, and sensory changes to the bottoms of his feet. The injured worker's physical exam revealed a positive straight leg raise, muscle spasm of the spine, guarding in the shoulders and upper back, and decreased sensation in the 4th and 5th fingers bilaterally. The injured workers reflexes were trace 1+ the right biceps, 2+ at the left biceps, 0 at the left triceps, trace at the right triceps, 2+ at the left knee, 0 at the right knee, 1+ at the right ankle, and trace at the left ankle. There was limited range of motion noted to the neck, bilateral shoulders, and low back. The MRI of the lumbar spine revealed degeneration of 2-3, 3-4, 4-5, and 5-1, there were no significant stenosis and no evidence of any significant nerve root compression centrally or in the foramen. The injured worker's diagnoses were cervical radiculopathy/myelopathy with torticollis, thoraco-lumbar scoliosis from spasm, post tramatic headaches, bilateral shoulder distruption, and post concussive syndrome. The provider recommended Depakote ER 500MG, a lumbar MRI, and lab work. The request for authorization form was not included in the medical documents.

IMR ISSUES, DECISIONS AND RATIONALES

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

DEPAKOTE ER 500MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-EPILEPSY DRUGS (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-EPILEPSY DRUGS (AED'S) Page(s): 16.

Decision rationale: The request for Depakote 500MG is non-certified. The California MTUS guidelines recommend Depakote as an effective treatment for diabetic neuropathy and postherpic neuralgia. It is not recommended for myofacial pain. There is a lack of evidence to demonstrate that AEDs significantly reduce the level of myofascial or other sources of somatic pain. The provider recommended Depakote for headache prophylaxis. The provided medical documents do not include diagnoses that would be congruent with the guideline recommendations, and there is no quantity specified in the request. Therefore, the request is not medically necessary.

LUMBAR MRI: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRI Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRI Section.

Decision rationale: The request for a Lumbar MRI is non-certified. The injured worker had decreased sensation in the 4th and 5th fingers bilaterally. The injured workers reflexes were 2+ at the left knee, 0 at the right knee, 1+ at the right ankle, and trace at the left ankle. The Official Disability Guidelines recommend MRI's for injured workers with prior back surgery, at least one month of conservative therapy, or a progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant. Per the provided documentation the injured worker previously underwent an MRI of the lumbar spine the date of which was unclear. The included medical documents also make reference to a normal EMG which showed no abnormal findings. It was unclear if the injured worker had a significant change in symptoms or findings indicative of significant pathology. Therefore, the request is not medically necessary.

LAB WORK: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.nlm.nih.gov/medlineplus.ency/article/003686.htm.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 70.

Decision rationale: The request for lab work is non-certified. The California MTUS guidelines recommend periodic lab monitoring of a CBC and chemistry profile, including liver and renal function tests. There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. The requesting physician's rationale for the request was unclear. Additionally, it was unclear what specific lab tests were being requested. As such, the request is not medically necessary.