

Case Number:	CM15-0105684		
Date Assigned:	06/10/2015	Date of Injury:	12/03/2002
Decision Date:	07/13/2015	UR Denial Date:	05/14/2015
Priority:	Standard	Application Received:	06/02/2015

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, Alabama, 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 61-year-old male, who sustained an industrial injury on December 3, 2002 while working as a truck driver. The mechanism of injury was a slip and fall. The injured worker has been treated for low back complaints. The diagnoses have included low back pain, spasm of muscle, post-laminectomy syndrome, hyperglycemia related to industrial injury, chronic pain and mood disorder. Treatment to date has included medications, radiological studies, MRI, epidural steroid injections, psychiatric evaluations and lumbar spine surgery times two. Current documentation dated May 1, 2015 notes that the injured worker reported low back pain with radiation to the bilateral lower extremities. Associated symptoms included numbness and tingling of the bilateral feet to the calves. The pain was noted to be unchanged from the prior visit. The pain was rated a seven out of ten on the visual analogue scale with medications. Examination of the lumbar spine revealed tenderness to palpation of the paravertebral muscles, spasm and a tight muscle band on both sides. Lumbar facet loading was positive on both sides. A straight leg raise test was positive on the left side. A right straight leg raise test produced pain in the lower back. The treating physician's plan of care included a request for the medications Folic Acid 20 mg # 30 with 3 refills, Glimepiride 4 mg # 30 with 3 refills and Abilify 15 mg # 30 with 3 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Folic Acid 20 MG #30 with 3 Refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Folate (for depressive disorders). <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, folic acid is not recommended for the treatment of mood disorders. (Under study, the limited available evidence suggests folate may have a potential role as a supplement to other treatment for depression). There is no documentation that the patient developed a folic acid deficit. There is no evidence supporting the use of folic acid for pain management. Therefore, the request is not medically necessary.

Glimepiride 4 MG #30 with 3 Refills: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Sulfonylurea. <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, Sulfonylurea (Glimperide) "Not recommended as a first-line choice, but may be recommended as a safe alternative to thiazolidinedione treatment." Some authors report that sulfonylureas are safer compared to thiazolidinediones because they give a better and faster improvement of glycated hemoglobin without giving the adverse effects reported with the use of thiazolidinediones. There is no documentation that the patient is diabetic and the need for Glimperide is not clear. The request is not medically necessary.

Abilify 15 MG #30 with 3 Refills: 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), Mental Illness.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aripiprazole (Abilify). <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, Aripiprazole (Abilify) "Not recommended as a first-line treatment. Abilify (aripiprazole) is an antipsychotic medication. Antipsychotics are the first-line psychiatric treatment for schizophrenia. There is insufficient evidence to recommend atypical antipsychotics for conditions covered in ODG. See atypical antipsychotics;

and PTSD pharmacotherapy. See also Anxiety medications in chronic pain in the Chronic Pain Chapter. According to a recent Cochrane systematic review, aripiprazole is an antipsychotic drug with a serious adverse effect profile and long-term effectiveness data are lacking. (Khanna, 2014) Aripiprazole is approved for schizophrenia and acute mania, and as an adjunct second-line therapy for bipolar maintenance and major depressive disorder. It is not approved or shown to be effective for personality disorder, substance abuse, or insomnia. (FDA, 2014)" There is no documentation that the patient is suffering from a schizophrenia. Therefore, the request for Abilify 15 MG #30 with 3 Refills is not medically necessary.