

<b>Case Number:</b>	CM13-0060000		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	08/08/2013
<b>Decision Date:</b>	06/12/2014	<b>UR Denial Date:</b>	11/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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 Internal Medicine, and is licensed to practice in Virginia, and Washington DC. 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:

This is a 28-year-old female who sustained an injury on Aug. 8, 2013, and suffered from headaches, after working in a strawberry field and being struck by an unknown object. She had issues with photophobia, phonophobia, dizziness and tearing. She suffered a hematoma following the initial injury. She had a head computed tomography (CT) scan on Aug. 8, 2013, which did not show an intracranial bleed. The patient was seen by a consultant on Aug 8, 2013, following the initial injury and no neurologic signs were noted on exam. Another physician saw the patient on Aug. 13, 2013 and also noted no neurologic signs on examination. The patient was diagnosed with post-concussion syndrome and given ibuprofen. The physician saw the patient on Sept. 18, 2013, and noted that the patient had ongoing headache pain, but a normal exam. A different physician saw the patient on Oct. 10, 2013, for headache and noted a normal neurologic exam. He prescribed ultracet for the patient. Another physician saw the patient on Nov. 18, 2013 for migraine headache. The neurologic exam was normal. Further studies were ordered which included: electroencephalogram (EEG), MRI head, thyroid-stimulating hormone (TSH), blood sugar and other baseline lab tests such as hepatic panel, complete blood count (CBC), erythrocyte sedimentation rate (ESR), A1C. The patient was prescribed folic acid, gabapentin, lexapro.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONE (1) PRESCRIPTION OF FOLIC ACID 1MG #90, WITH THREE (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  
[HTTP://EMEDICINE.MEDSCAPE.COM/ARTICLE/1142556-TREATMENT#AW2AAB6B6B9](http://EMEDICINE.MEDSCAPE.COM/ARTICLE/1142556-TREATMENT#AW2AAB6B6B9).

**Decision rationale:** There are no specific MTUS guidelines addressing migraine headache workup. Pharmacologic agents used for the treatment of migraine can be classified as abortive, such as for alleviating the acute phase or prophylactic, such as preventive. Abortive medications include the following: Selective serotonin receptor (5-HT1) agonists (triptans), Ergot alkaloids, Analgesics, Non-steroidal anti-inflammatory drugs (NSAIDs), combination products, and antiemetics. Prophylactic medications include the following: Antiepileptic drugs, Beta blockers, Tricyclic antidepressants, Calcium channel blockers, Selective serotonin reuptake inhibitors (SSRIs), NSAIDs, Serotonin antagonists, and Botulinum toxin. Folic acid usage for treatment of migraine is still under experimental investigation and therefore not medically indicated. The patient had no evidence of anemia which would warrant this usage as well.

**ONE (1) ROUTINE LAB FOR COMPLETE BLOOD COUNT (CBC), HEPATIC PROFILE, ERYTHROCYTE SEDIMENTATION RATE (ESR), THYROID-STIMULATING HORMONE (TSH), HEMOGLOBIN A1C, BLOOD GLUCOSE:**  
Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation BEITHON J, GAILENBERG M, JOHNSON K, KILDAHL P, KRENIK J, LIEBOW M, LINBO L, MYERS C, PETERSON S, SCHMIDT J, SWANSON J. DIAGNOSIS AND TREATMENT OF HEADACHE. BLOOMINGTON (MN): INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT (ICSI); 2013 JAN. 90 P.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation  
[HTTP://EMEDICINE.MEDSCAPE.COM/ARTICLE/1142556-WORKUP](http://EMEDICINE.MEDSCAPE.COM/ARTICLE/1142556-WORKUP); CHAR DB, YOUNG WB, ROSENBERG JA, ET AL. EVIDENCE-BASED GUIDELINES FOR MIGRAINE HEADACHE IN THE PRIMARY CARE SETTING: PHARMACOLOGICAL MANAGEMENT OF ACUTE ATTACKS. AMERICAN ACADEMY OF NEUROLOGY. ACCESSED FEBRUARY 10, 2011 AND [HTTP://LABORATORY-MANAGER.ADVANCEWEB.COM/ARCHIVES/ARTICLE-ARCHIVES/NEW-ADA-GUIDELINES-FOR-DIAGNOSIS-SCREENING-OF-DIABETES.ASPX](http://LABORATORY-MANAGER.ADVANCEWEB.COM/ARCHIVES/ARTICLE-ARCHIVES/NEW-ADA-GUIDELINES-FOR-DIAGNOSIS-SCREENING-OF-DIABETES.ASPX).

**Decision rationale:** There are no specific MTUS guidelines addressing migraine headache workup. Migraine is a clinical diagnosis. Diagnostic investigations are performed for the following reasons: Exclude structural, metabolic, and other causes of headache that can mimic or coexist with migraine; Rule out co-morbid diseases that could complicate headache and its treatment; Establish a baseline for treatment and exclude contraindications to drug

administration; Measure drug levels to determine compliance, absorption, or medication overdose. The choice of laboratory and/or imaging studies is determined by the individual presentation. For example, in an older person with compatible findings, such as scalp tenderness, measurement of erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) may be appropriate to rule out temporal/giant cell arteritis. Given that the patient had persistent symptoms of headache; the additional work up is medical indicated.