

<b>Case Number:</b>	CM14-0148392		
<b>Date Assigned:</b>	10/17/2014	<b>Date of Injury:</b>	03/09/2007
<b>Decision Date:</b>	11/18/2014	<b>UR Denial Date:</b>	08/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2014

### 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 Emergency Medicine, and is licensed to practice in New York. 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 patient is a 46-year-old male who was injured on March 9, 2007. The patient continued to experience headaches and pain in his lower back. Physical examination was notable for tenderness over the cervical bony prominences, decreased range of motion of the cervical spine, pain with lumbar facet loading, and decreased sensation in the bilateral S1 distributions, and positive straight leg raise bilaterally. Diagnoses included traumatic brain injury following left front temporal skull fracture with associated subdural hematoma, posttraumatic labyrinthitis, chronic low back pain, chronic left knee pain, posttraumatic migraine headaches, chronic left-sided neck pain, and post concussive syndrome. Treatment included acupuncture, physical therapy, occipital nerve blocks, epidural steroid injections, surgery, and medications. Requests for authorization for Hydrocodone/APAP 10/325 mg #60, gabapentin 600 mg #60 with 5 refills, and Imitrex 50 mg 9 tablets with 3 refills were submitted for consideration.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective 60 Tablets of Hydrocodone/APAP 10/325MG (Date of service 5/7/14):**

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 11, 74-96.

**Decision rationale:** Hydrocodone/APAP is the compounded medication containing hydrocodone and acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDs have failed. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case the patient had not taken the opioids for 3 months. There is no documentation of duration or effectiveness of the opioids prior to that. In addition there is no documentation that the patient had signed an opioid contract or was participating in urine drug testing. The request is not medically necessary.

**Retrospective 60 Tablets of Gabapentin 600 Mg with 5 Refills (Date of service 5/7/14):**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines, Page(s): 18-19.

**Decision rationale:** Gabapentin is an anti-epileptic medication. Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain and has FDA approval for treatment of post-herpetic neuralgia. Gabapentin appears to be effective in reducing abnormal hypersensitivity, to have anti-anxiety effects, and may be beneficial as a sleep aid. Gabapentin has a favorable side-effect profile, few clinically significant drug-drug interactions and is generally well tolerated; however, common side effects include dizziness, somnolence, confusion, ataxia, peripheral edema, dry mouth, and weight gain. It has been recommended for the treatment of pain from spinal cord injury, fibromyalgia, lumbar spinal stenosis, and chronic regional pain syndrome. Recommended trial period is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. If inadequate control of pain is found, a switch to another first-line drug is recommended. In this case the patient had not taken Gabapentin in 3 months. There is no documentation of the duration of efficacy of treatment with Gabapentin.

Lack of documentation does not allow determination of efficacy. The request is not medically necessary

**Retrospective 9 tablets of Imitrex 50mg with 3 refills (Date of service 5/7/14): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Workers' Compensation, Online edition; Chapter: HeadTriptans

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Insert Section (for example Knee)>, Triptans

**Decision rationale:** Imitrex is the Triptans medication, Sumatriptan. Triptans are recommended for migraine sufferers. At marketed doses, all oral Triptans are effective and well tolerated. Differences among them are in general relatively small, but clinically relevant for individual patients. In this case the patient is not suffering from migraine headaches. His posttraumatic headaches do not have the same physiology as migraine headaches. Triptans are not indicated. The request is not medically necessary.