

<b>Case Number:</b>	CM14-0140243		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	07/06/1999
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	08/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2014

### 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 and Oklahoma. 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 53-year old female with a reported date of injury on 07/06/1999. The mechanism of injury was not noted in the records. The diagnoses included chronic low back pain and right shoulder pain. The past treatments included pain medication and pool therapy. There was no surgical history noted in the records. The subjective complaints on 08/07/2014 consisted of low back pain. The physical examination noted tenderness of the cervical, thoracic and lower lumbar region and limited range of motion to the lumbar spine. The medications consisted of Topamax, Zanaflex, Opana ER, Opana IR, Axert, and Ibuprofen. The treatment plan was to continue medications and pool therapy. The rationale and request for authorization form were not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Axert 12.5mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Keam, SJ; KL;Figgitt, DP (2002). Almotriptan: a review of its use in migraine. *Drugs* 62 (2): 387-414

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head, Triptans.

**Decision rationale:** The request for Axert 12.5mg #30 is not medically necessary. The Official Disability Guidelines state Triptans are recommended for migraine sufferers and all oral Triptans are effective and well tolerated. The injured worker has chronic low back pain. There was no clear documentation in the notes that she had headaches or migraine headaches. Additionally, there were no documented symptoms or objective findings to support migraines headaches. In the absence of clear evidence that the injured worker suffers from migraine headaches the request is not supported by the guidelines. As such, the request is not medically necessary.