

<b>Case Number:</b>	CM13-0017457		
<b>Date Assigned:</b>	09/27/2013	<b>Date of Injury:</b>	07/05/1990
<b>Decision Date:</b>	02/18/2014	<b>UR Denial Date:</b>	07/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California. 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 physician 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 physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records: This 51-year-old male reported an injury on 7/5/90. The mechanism of injury was not submitted for review. The patient was diagnosed with tension headaches. The clinical note dated 7/11/12 signed by [REDACTED] indicated the patient presented for evaluation. The note indicated the patient underwent Botox neurolysis on 4/18/12 with reports of 70% decrease in prior cervical dystonia and anterolisthesis. The patient reported persistent severe right occipital and right posterolateral neck spasm, pain, and tenderness rated at 8/10 on the visual analog scale (VAS). He reported excellent stimulation paresthesia coverage to the area. He utilized Kadian 50mg every 8 hours and MSIR 15mg 1 to 2 tablets 3 times a day as needed, resulting in a decrease in bilateral cervical and shoulder myofascial spasms and tenderness present in the bilateral sternocleidomastoid, bilateral anterior scalene, bilateral trapezius, and bilateral levator scapula muscles. Cervical range of motion (ROM) was decreased in all planes. ROM of the cervical spine on flexion was 25 degrees, extension 25 degrees, lateral flexion to the left 35 degrees, lateral flexion to the right 45 degrees, left rotation 50 degrees, and right rotation 60 degrees. The clinical note dated 9/5/12 signed by [REDACTED] indicated the patient presented for evaluation. The patient reported a return of the cervical dystonia and anterolisthesis since mid August 2012, which was previously decreased by about 70% following the Botox neurolysis on 4/18/12. The patient reported decreased right occipital and right posterolateral neck spasms, pain, and tenderness with a pain rating of 4/10 on the VAS. He reported utilizing Kadian 50mg every 8 hours and MSIR 15mg 1 to 2 tablets 3 times a day as needed. On physical examination, the patient was noted to have anterocollis and cervical dystonia. There were prominent myofascial spasms and tenderness present in the bilateral sternocleidomastoid; bilateral anterior scalene, bilateral trapezius, and bilateral levator scapula muscles. Cervical

ROM was decreased. ROM on flexion was 25 degrees, left rotation 50 degrees, and right rotation 60 degrees. The patient was recommended to undergo Botox neurolysis to treat the cervical dystonia and anterolisthesis. The note indicated the prior Botox neurolysis was performed on 4/18/12 with a 70% improvement.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**The request for Botox Neurolysis:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum Toxin (Botox; Myobloc). Page(s): 25-26.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section on Botox Page(s): 25-26.

**Decision rationale:** CA-MTUS(Effective July 18 2009) page 25 to 26 of 127 section on Botulinum toxin (Botox®; Myobloc®): Not generally recommended for chronic pain disorders, but recommended for cervical dystonia. See more details below. Not recommended for the following: tension-type headache; migraine headache; fibromyositis; chronic neck pain; myofascial pain syndrome; & trigger point injections. Several recent studies have found no statistical support for the use of Botulinum toxin A (BTXA) for any of the following: - The evidence is mixed for migraine headaches. This RCT found that both botulinum toxin type A (BoNTA) and divalproex sodium (DVPX) significantly reduced disability associated with migraine, and BoNTA had a favorable tolerability profile compared with DVPX. (Blumenfeld, 2008) In this RCT of episodic migraine patients, low-dose injections of BoNTA into the frontal, temporal, and/or glabellar muscle regions were not more effective than placebo. (Saper, 2007) Botulinum neurotoxin is probably ineffective in episodic migraine and chronic tension-type headache (Level B). (Naumann, 2008) - Myofascial analgesic pain relief as compared to saline. (Qerama, 2006) - Use as a specific treatment for myofascial cervical pain as compared to saline. (Ojala, 2006) (Ferrante, 2005) (Wheeler, 1998) - Injection in myofascial trigger points as compared to dry needling or local anesthetic injections. (Kamanli, 2005) (Graboski, 2005). Recent systematic reviews have stated that current evidence does not support the use of BTX-A trigger point injections for myofascial pain. (Ho, 2006) Or for mechanical neck disease (as compared to saline). (Peloso-Cochrane, 2006) A recent study that has found statistical improvement with the use of BTX-A compared to saline. Study patients had at least 10 trigger points and no patient in the study was allowed to take an opioid in the 4 weeks prior to treatment. (Gobel, 2006) Recommended: cervical dystonia, a condition that is not generally related to workers' compensation injuries (also known as spasmodic torticollis), and is characterized as a movement disorder of the nuchal muscles, characterized by tremor or by tonic posturing of the head in a rotated, twisted, or abnormally flexed or extended position or some combination of these positions. When treated with BTX-B, high antigenicity limits long-term efficacy. Botulinum toxin A injections provide more objective and subjective benefit than trihexyphenidyl or other anticholinergic drugs to patients with cervical dystonia. Recommended: chronic low back pain, if a favorable initial response predicts subsequent responsiveness, as an option in conjunction with a functional restoration program. Some additional new data suggests that it may

be effective for low back pain. (Jabbari, 2006) (Ney, 2006) Botulinum neurotoxin may be considered for low back pain (Level C). (Naumann, 2008). The patient notes return of the bitemporal and frontal headache rated 6/10. The patient underwent the appr