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| Case Number: | CM13-0061520 | | |
| Date Assigned: | 12/30/2013 | Date of Injury: | 05/11/2011 |
| Decision Date: | 06/27/2014 | UR Denial Date: | 11/06/2013 |
| Priority: | Standard | Application Received: | 12/05/2013 |

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 Occupational Medicine 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 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 51 year old female who was injured on May 11, 2011. She reported she was speed walking down an outdoor hallway while looking to her left to talk to a student. She quickly turned around and bumped into an open wooden door. She felt an immediate sharp headache. Prior treatment history has included physical therapy and acupuncture. The patient underwent a C2, C3, C4 radiofrequency ablation performed on August 30, 2013. Diagnostic studies reviewed include arthrogram of the left shoulder dated March 1, 2013 revealed supraspinatus and subscapularis tendonosis and osteoarthritic changes of het acromioclavicular joint. There is a laterally down sloping acromion process, placing the patient at a higher risk for impingement and diminutive appearance to the anterior superior labrum along with thickening of the middle glenohumeral ligament. The appearance is most suggestive of a Buford complex. Office note dated October 24, 2013 indicated the patient returned for an evaluation. She received a botulinum toxin on August 28, 2013 for the first time. She was significantly better. The intensity of the head pain mostly was down. Maxalt was reduced as well as her analgesic use. She was still having at least 3 headaches per week for which she needed to use the Triptan. Based on this reduction in symptomatology, request for botulinum toxin again in mid November was made. The physical examination revealed improved range of motion of the neck. There was less tenderness. The assessment is chronic migraine without aura and arthropathy of the cervical spine. The plan if for the patient to continue with posture, stretching and spray and stretch, continue with the current medications, continue with behavioral interventions and obtain authorization for repeat botulinum toxin in mid November.

IMR ISSUES, DECISIONS AND RATIONALES

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

BOTOX INJECTIONS, 200 UNITS EVERY THREE (3) MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Tension-type headache; Page(s): 26.

Decision rationale: The request is for Botulium Toxin for chronic headaches (migraines). Generally all guidelines do not recommend these injections for migraine type headaches including ACOEM, California MTUS and ODG Guidelines. The request is not medically necessary.