

Case Number:	CM14-0156977		
Date Assigned:	09/29/2014	Date of Injury:	06/29/2000
Decision Date:	11/19/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/25/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 35 year old woman who sustained a work-related injury on September 29, 2000. Subsequently, chronic neck pain. According to a progress report dated on February 21, 2014, the patient was complaining of chronic neck pain which was aggravated by lifting pushing and daily activity. The pain is relieved by any ice, injection, massage, physical therapy and rest. Without medication, the patient pain was rated 10 over 10 and 6/10 with medications. Her physical examination was significant for cervical tenderness with reduced range of motion. The patient was diagnosed with the cervical radiculopathy, chronic pain, migraines and insomnia. The patient was treated with Imitrex and Trazodone and Effexor. Previously, he was treated with the bilateral C7 epidural injection on June 18, 2015 and had 80% improvement of her pain over four-month. The provider requested authorization to use Botox, cervical epidural injection, and Naproxen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Botox injections (200 units): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin Page(s): 25-26.

Decision rationale: According to MTUS guidelines, Botulinum toxin is < Not generally recommended for chronic pain disorders, but recommended for cervical dystonia. 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 typeA (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)>. In summary and according to MTUS guidelines, Botulinum toxin is not generally recommended for chronic pain disorders, but recommended for cervical dystonia. It is not recommended for migraine headache, tension headache, chronic neck pain, trigger point injection, and myofascial pain. In addition, there is no documentation that the patient failed classic migraine headache medications. Therefore, the request for Botox injections (200 units) is not medically necessary and appropriate.

Transforaminal epidural cervical injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: According to MTUS guidelines, epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit; however there is no significant long term benefit or reduction for the need of surgery. Furthermore, the patient file does not document that the patient is candidate for surgery. In addition, and although the patient have some evidence of benefit from a previous epidural injection, there is no evidence that the patient have signs of active radiculopathy at this time. MTUS guidelines do not recommend epidural injection without documentation of radiculopathy. Therefore, Transforaminal epidural cervical injection is not medically necessary and appropriate.

Naproxen 500mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen
Page(s): 66.

Decision rationale: There is no documentation of the rationale behind the long term use of Naproxen. NSAID should be used for the shortest duration and the lowest dose. There is no documentation from the patient file that the provider titrated Naproxen to the lowest effective dose and used it for the shortest period possible. Naproxen was used continuously without clear documentation of its efficacy. There is objective documentation of pain and functional improvement with continuous use of Naproxen. Furthermore, there is no documentation that the provider followed the patient for NSAID adverse reactions that are not limited to GI side effect, but also may affect the renal function and blood pressure. In addition, there is no recent documentation of acute pain exacerbation that may justify the use of Naproxen. Therefore, the request for Naproxen 500mg is not medically necessary and appropriate.