

<b>Case Number:</b>	CM15-0169863		
<b>Date Assigned:</b>	09/10/2015	<b>Date of Injury:</b>	01/14/2014
<b>Decision Date:</b>	10/08/2015	<b>UR Denial Date:</b>	08/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: North Carolina

Certification(s)/Specialty: Family Practice

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 46 year old woman sustained an industrial injury on 1-14-2014. The mechanism of injury is not detailed. Diagnoses include chronic symptoms of myofascial pain syndrome to the scapular and trapezius with symptoms of thoracic outlet syndrome and pertinent hypertonicity to the muscles around the left shoulder and thoracic outlet muscles causing shaking of the left upper extremity with active range of motion. Treatment has included oral medications, Botox injections, chiropractic care, physical therapy, and functional restoration program. Physician notes dated 8-19-2015 show complaints of continued left scapula pain with radiation to the ribcage. The physical examination shows restricted range of motion in the shoulder with upper extremity shaking and tenderness over the scapula musculature and hypertonicity, tenderness over the ribcage and sternocostal junction, reduction of pinprick sensation in the ulnar nerve distribution in the left hand, and generalized weakness to the left upper extremity. Recommendations include additional Botox injections, additional physical therapy, home exercise program, and psychology sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Botox injections directed to left teres major, latissimus dorsi & other thoracic outlet musculature:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Botulinum toxin (Botox Myobloc).

**Decision rationale:** The California chronic pain medical treatment guidelines section on botulism toxin states: 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 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 anti-genicity 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 requested medication is usually only indicated in the treatment of cervical dystonia. The patient does not have this diagnosis. Therefore, the request is not medically necessary.

**6 sessions of physical therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. The patient has already completed a course of physical therapy. There is no objective explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. The request is not medically necessary.