

Case Number:	CM15-0215517		
Date Assigned:	11/05/2015	Date of Injury:	08/12/2014
Decision Date:	12/16/2015	UR Denial Date:	10/22/2015
Priority:	Standard	Application Received:	11/02/2015

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:

The injured worker is a 33 year old female who sustained an industrial injury on 08-12-2014. A review of the medical records indicated that the injured worker is undergoing treatment for closed head injury, cervical spine strain, headaches and temporomandibular joint syndrome. According to the treating physician's progress report on 10-19-2015, the injured worker continues to experience headaches and neck pain rated at 8-9 out of 10 on the pain scale. Examination demonstrated cervical tenderness and muscle spasms noted in the paraspinal musculature with decreased cervical spine range of motion by approximately 20%. There was decreased sensation on the right at C5-8 with deep tendon reflexes and motor strength intact. Lhermitte's and Spurling's signs were equivocal on the right. The injured worker had a normal gait. X-rays of the cervical spine and right shoulder performed on 11-10-2014 were read as normal studies. Prior treatments have included diagnostic testing, neurology consultation, pain management evaluation and treatment and medications. Current medications dispensed as of 06-2015 were listed as Anaprox, Fexmid and Ultram. Treatment plan consists of second opinion for pain management, cervical spine magnetic resonance imaging (MRI), dental consultation, transfer care to neurology, psychological counseling, Topamax and the current request for Botox Injections 155 units, chemo denervation of muscles innervated by facial nerve x 1, chemo denervation neck muscle x 1 and follow-up visits times three. The Utilization Review modified the request for follow-up visits times three to follow-up visits times one on 10-22-2015 and determined the request for Botox Injections 155 units, chemo denervation of muscles innervated by facial nerve x 1, chemo denervation neck muscle x 1 was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Botox Injections 155 units, Chemo denervation of muscles innervated by facial nerve x 1, Chemo denervation neck muscle x 1: Upheld

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

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 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 requested medication is usually only indicated in the treatment of cervical dystonia. It does not have the indication for the patient's condition per the ACOEM. Therefore the request is not medically necessary.

Follow Up visits x 3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Clinical office visits.

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

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ODG states follow up medical visits are based on medical necessity and the patient's progress, symptoms and ongoing complaints. However, the requested procedure has been denied and therefore follow up visits with this procedure are no necessary. Therefore, the request is not medically necessary.