MAXIMUS Federal Services

Case Number:	CM15-0032315		
Date Assigned:	02/25/2015	Date of Injury:	03/20/1995
Decision Date:	04/03/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	02/20/2015

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 62 year old female who sustained an industrial related injury on 3/20/98. The injured worker had complaints of head and upper extremity pain. Diagnoses included brachial neuritis/radiculitis, reflex sympathetic dystrophy of the upper extremity, spasmodic torticollic/cervical dystonia, and cervical spinal stenosis. Treatment included Botox injections to the head and neck for laterocollis and dystonia which was noted to be beneficial. Medication included Imitrex, Lunesta, Tylenol with Codeine, Baclofen, Zanaflex, and Meloxicam. The treating physician requested authorization for 4 Boxtox injections 1 vial every 3 months for one year between 12/17/14 and 2/6/16. On 2/9/15 the request was non-certified. The utilization review physician cited the Medical Treatment Utilization Schedule guidelines and noted the guidelines state that botulinum toxin is recommended for cervical dystonia and that this condition is generally not related to workers' compensation injuries. Additional and repeat injections do not appear to be warranted. Therefore the request was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Botox injections x 4; 1 vial every 3 months for 1 year: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin (Botox).

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

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 torticolis), 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 otheranticholinergic 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. Per the California MTUS it does not have the indication in the treatment of other diagnosis. The patient is being treated of this condition and therefore the request is certified.