

Case Number:	CM15-0050395		
Date Assigned:	03/23/2015	Date of Injury:	09/02/2002
Decision Date:	05/04/2015	UR Denial Date:	02/20/2015
Priority:	Standard	Application Received:	03/17/2015

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: California
 Certification(s)/Specialty: Dentist

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 61 year old male, who sustained an industrial injury on 9/2/02. The injured worker was diagnosed as having myofascial pain dysfunction, myalgia, clenching/bruxism/parafunction, status post endosseous implant placement, lost PFM crowns due to clenching and fracture tooth below gum line with retained root. Treatment to date has included previous multiple crowns and root canal. Currently, the injured worker complains of three crowns on lower right came off and slight discomfort to cold. The treatment plan included extraction of multiple fractured teeth replaced with implants and Botox in bilateral deep and superficial masseter and anterior, middle and posterior temporalis muscles bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

Botox Injection Right Deep Masseter Muscle: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin (Botox; Myobloc) Page(s): 25.

Decision rationale: Records reviewed indicate that this patient has severe parafunctional bruxism and clenching with myofascial pain dysfunction. 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), page 25 MTUS guidelines does not recommend Botox injections for chronic pain disorders except for cervical dystonia, which this patient does not have. Therefore, this IMR reviewer finds this request of Botox trigger point injections not medically necessary for this patient.

Botox Injection Left Deep Masseter Muscle: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin (Botox; Myobloc) Page(s): 25.

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(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) MTUS guidelines do not recommend Botox injections for chronic pain disorders except for cervical dystonia, which this patient does not have. Therefore, this IMR reviewer finds this request of Botox trigger point injections not medically necessary for this patient.

Botox Injection Right Superficial Masseter: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin (Botox; Myobloc) Page(s): 25.

Decision rationale: Records reviewed indicate that this patient has severe parafunctional bruxism and clenching with myofascial pain dysfunction. 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), page 25. MTUS guidelines do not recommend Botox injections for chronic pain disorders except for cervical dystonia, which this patient does not have. Therefore, this IMR reviewer finds this request of Botox trigger point injections not medically necessary for this patient.

Botox Injection Left Superficial Masseter: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Botulinum toxin (Botox; Myobloc) Page(s): 25.

Decision rationale: Records reviewed indicate that this patient has severe parafunctional bruxism and clenching with myofascial pain dysfunction. 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), page 25. MTUS guidelines does not recommend Botox injections for chronic pain disorders except for cervical dystonia, which this patient does not have. Therefore, this IMR reviewer finds this request of Botox trigger point injections not medically necessary for this patient.

Botox Injection Right Anterior Temporalis: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Botulinum toxin (Botox; Myobloc) Page(s): 25.

Decision rationale: 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), page 25.

Mandibular Temporary Stayplate, Bone Graft of Teeth #22, #24, #27, #28; Endosseous Implant of Teeth #22, #24, #27, #28, Diagnostic Wax of Teeth #22, #23, #24, #25, #26, #27, #28, Provisional Crown of Teeth #22, #23, #24, #25, #26, #27, #28, Interim Implant Abutment Teeth #22, #24, #25, #26, #27, #28: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head procedure summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG HeadDental trauma treatment (facial fractures).

Decision rationale: Records reviewed indicate that this patient has severe parafunctional bruxism and clenching and frequent fracturing off of numerous teeth at the gum line due to sever loss of tooth structure from grinding and erosion and patient will need extractions of non-restorable teeth #'s 22,23,24,25,26,27,28. Per reference mentioned above, "A tooth that is vertically fractured or fractured below the gum line will require root canal treatment and a protective restoration. If there is no sufficient structure remaining to hold a crown, tooth extraction may be needed, and bridges, implants or a removable appliance may be used. Rather than resting on the gum line like removable dentures, or using adjacent teeth as anchors like fixed bridges, dental implants are long-term replacements. The goal of replacing missing teeth while respecting otherwise untouched tooth structure and the avoidance of crown reduction in bridge preparation make the use of dental implants an option for restoring traumatic tooth loss. The placement of dental implants can have deleterious effects on the growing alveolar process, and it is necessary to delay implant reconstruction until the cessation of skeletal or alveolar growth. In situations where replacement of the tooth is accomplished by dental implants, the dental crown is also included." Recommended Traumas to the oral region occur frequently and comprise 5 percent of all injuries for which people seek treatment. Among all facial injuries, dental injuries are the most common, of which crown fractures and luxations occur most frequently. An appropriate treatment plan after an injury is important for a good prognosis. The International Association of Dental Traumatology (IADT) has developed guidelines for the evaluation and management of traumatic dental injuries. Dental implants, dentures, crowns, bridges, onlays, inlays, braces, pulling impacted teeth, or repositioning impacted teeth, would be options to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury. Any dental work needed due to underlying conditions unrelated to the industrial injury would be the responsibility of the worker. If part of the tooth is lost, but the pulp is not irrevocably damaged, a porcelain veneer or crown may be used. If the pulp has been seriously damaged, the tooth will require root canal treatment before a crown. A tooth that is vertically fractured or fractured below the gum line will require root canal treatment and a protective restoration. If there is no sufficient structure remaining to hold a crown, tooth extraction may be needed, and bridges, implants or a removable appliance may be used. Rather than resting on the gum line like removable dentures, or using adjacent teeth as anchors like fixed bridges, dental implants are long-term replacements. The goal of replacing missing teeth while respecting otherwise untouched tooth structure and the avoidance of crown reduction in bridge preparation make the use of dental implants an option for restoring traumatic tooth loss.

The placement of dental implants can have deleterious effects on the growing alveolar process, and it is necessary to delay implant reconstruction until the cessation of skeletal or alveolar growth. In situations where replacement of the tooth is accomplished by dental implants, the dental crown is also included. Therefore this reviewer finds this request for Mandibular Temporary Stayplate, Bone Graft of Teeth #22, #24, #27, #28; Endosseous Implant of Teeth #22, #24, #27, #28, Diagnostic Wax of Teeth #22, #23, #24, #25, #26, #27, #28, Provisional Crown of Teeth #22, #23, #24, #25, #26, #27, #28, Interim Implant Abutment Teeth #22, #24, #25, #26, #27, #28, Implant Crown of Teeth #22, #23, #24, #25, #26, #27, #28, Custom Abutment of Teeth #22, #24, #25, #27, #28 to be medically necessary to properly treat this patient's dental condition on a long-term basis.