

Case Number:	CM15-0067682		
Date Assigned:	05/05/2015	Date of Injury:	01/03/2013
Decision Date:	07/09/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	04/09/2015

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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 52 year old male with an industrial injury dated 01/03/2013. He was caught between a forklift and metal racks. The forklift pushed on his left jaw and right side of his face. His diagnoses included head trauma, post-traumatic head syndrome, post-traumatic chronic daily headaches with migraine component, cervical sprain/strain - rule out cervical radiculopathy, disorder of sleep and arousal secondary to the above, psychological factors affecting the physical condition and tremor and temporomandibular joint dysfunction. Prior treatment included medications, chiropractic treatments and pain management. He presents on 02/04/2015 with complaints of problems with short and long-term memory, neck pain, difficulty chewing, sexual dysfunction and headaches. Physical exam noted the injured worker to be mildly apprehensive. There was tenderness to the sub occipital areas. There was a tremor noted to the outstretched hands. Range of motion of his neck was restricted at 70% of expected normal in flexion, extension and lateral bending. The provider notes the injured worker has had very little in the way of diagnostic studies and is requesting MRI of brain, EEG, EMG and nerve conduction studies of bilateral upper extremities, Botox chemo denervation and supplies for migraine, Topamax as a prophylactic medication for headaches, Midrin for headaches and gradual reduction of Valium and Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient MRI of the brain: Upheld

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

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

Decision rationale: ODG states "Neuroimaging is not recommended in patients who sustained a concussion/mild TBI beyond the emergency phase (72 hours post-injury) except if the condition deteriorates or red flags are noted. (Cifu, 2009) See also Diffusion tensor imaging (DTI)." ODG provides additional indications for magnetic resonance imaging: To determine neurological deficits not explained by CT; To evaluate prolonged interval of disturbed consciousness; To define evidence of acute changes super-imposed on previous trauma or disease. The treating physician does not document any injury, re-injury, focal neurologic deficits, red-flags, or a significant change in symptoms from the previous imaging. As such, the request is not medically necessary.

EEG/digital QEEG: Upheld

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

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

Decision rationale: ODG states the following: "Recommended as indicated below. EEG (electroencephalography) is a well-established diagnostic procedure that monitors brain wave activity using scalp electrodes and provocative maneuvers such as hyperventilation and photic strobe. Information generated includes alterations in brain wave activity such as frequency changes (nonspecific) or morphologic (seizures). EEG is not generally indicated in the immediate period of emergency response, evaluation, and treatment. Following initial assessment and stabilization, the individual's course should be monitored. See also QEEG (brain mapping). Indications for EEG: If there is failure to improve or additional deterioration following initial assessment and stabilization, EEG may aid in diagnostic evaluation." There is no evidence of failure to improve or deterioration after initial assessment. Therefore, the request is not medically necessary.

EMG/NCV of bilateral upper extremities (BUE): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Electromyography (EMG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 165-194. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM states "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." ODG states in the Low Back Chapter and Neck Chapter, "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." Medical records already indicate clinical obvious radiculopathy: numbness (worsening), tingling, and radiculopathy and EMG would not be indicated in this instance. As such, the request is not medically necessary.

Botox chemo denervation 100 units x 2 and botox supplies: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Head; Botox for migraines.

Decision rationale: ODG states the following: Recommended as indicated below for prevention of headache in patients with chronic migraine. Pooled results of 2 large, randomized, placebo-controlled trials show that botulinum toxin is an effective, safe, and well-tolerated treatment for the prevention of headache for patients with chronic migraine. (Dodick, 2009) On October 16, 2010, the FDA approved onabotulinumtoxin A (Botox; Allergan Inc) for headache prophylaxis in patients with adult chronic migraine who suffer headaches on 15 or more days per month, each lasting more than 4 hours. To treat chronic migraine, onabotulinumtoxin A is given approximately every 12 weeks as multiple injections around the head and neck to try to dull future headache symptoms. It has not been shown to work for the treatment of episodic migraine headaches that occur 14 days or fewer per month, or for other forms of headache. (FDA, 2010) Despite Botox being approved in the U.S. for use in chronic migraines, published evidence on the effectiveness of this treatment for headaches is limited, according to some. Botox treatment for migraine is costly, and the toxin can actually cause headaches, pain, stiffness, and muscle spasms, conclude these authors. (Iheanacho, 2011) Britain's National Institute for Health and Clinical Excellence (NICE) at first decided not to recommend Botox as a migraine treatment option on the state-run health service, but then they changed position, and now NICE recommends Botox for preventing headaches in adults who have chronic migraine. (NICE, 2012) According to this high quality meta-analysis, botulinum toxin A compared with placebo was associated with a small to modest benefit for chronic daily headaches and chronic migraines but was not associated with fewer episodic migraine or chronic tension-type headaches per month. (Jackson, 2012) onabotulinumtoxin A has been shown to reduce the frequency of headaches in patients with chronic migraine and can be considered a cost-effective use of resources. (Batty, 2013) For chronic migraine, onabotulinumtoxin A reduced migraine attacks but also increased the risk of adverse effects and treatment discontinuation due to adverse effects. (Shamliyan, 2013)

Botulinum toxin type A has gained a level of evidence based on the results of RCTs and pooled analysis, which by and large have shown at least a modest but valuable therapeutic effect. Considering the disabling nature of migraine disorder, the large prevalence and serious impact on health-related quality of life and health care costs, any degree of response to treatment is welcomed by the patient. (Proietti Cecchini, 2014) onabotulinumtoxinA continues to relieve migraine headache when given over the long term, according to a retrospective analysis of patients with chronic migraine treated for 9 treatment cycles, 12 weeks apart. The proportions of patients who were deemed to be incapacitated according to Migraine Disability Assessment scores were 53% at baseline and 7% at cycle 7. In addition, 50% of patients had a 5-point or greater reduction in Headache Impact Test-6 score by cycle 7 compared with their score at baseline. (Blumenfeld, 2014)Criteria for botulinum toxin (Botox) for prevention of chronic migraine headaches: An initial 12-week trial if all of the following are met: Diagnosed with chronic migraine headache; & more than 15 days per month with headaches lasting 4 hours a day or longer; & not responded to at least three prior first-line migraine prophylaxis medications, choose from: Amitriptyline, beta blockers (metoprolol, propranolol, and timolol), topiramate as well as valproic acid and its derivatives, are first-line agents for the treatment of chronic migraines. Continuing treatment for ongoing prevention: Frequency reduced by at least 7 days per month (when compared to pre-treatment average); or Duration was reduced by at least 100 hours per month (compared to pre-treatment). Discontinue if headache days reduced to less than 15 days a month over three consecutive months (qualifies as episodic migraine, not covered for Botox). The employee does not meet the above criteria. There is no report of failure of 3 first line migraine medications. Therefore, the request is not medically necessary.

Pharmacy purchase of Topamax 50mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epileptic drugs; Topamax Page(s): 21, 113.

Decision rationale: Topamax is the brand name version of Topiramate, which is an anti-epileptic medication. MTUS states that anti-epilepsy drugs are recommended for neuropathic pain, but do specify with caveats by medication. MTUS states regarding Topamax "has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. Topiramate has recently been investigated as an adjunct treatment for obesity, but the side effect profile limits its use in this regard." Medical files do not indicate the failure of other first line anticonvulsants, such as gabapentin. As such, the request for Topamax is not medically necessary.