

<b>Case Number:</b>	CM15-0084004		
<b>Date Assigned:</b>	05/06/2015	<b>Date of Injury:</b>	12/08/1981
<b>Decision Date:</b>	06/18/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2015

### 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: Internal 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 73 year old male who sustained an industrial injury on 12/08/1981. Diagnoses include industrial based cervical pain with radiculopathy, chronic cervical spasmodic component with an element of torticollis to the left by approximately 45 degrees. Treatment to date has included diagnostic studies, medications, Botox injections, physical therapy, acupuncture, use of a Transcutaneous Electrical Nerve Stimulation unit, biofeedback, and a home exercise program. A physician progress note dated 04/06/2015 documents the injured worker presents with complaints of cervical pain that has worsened. The injured worker has spasming, throbbing, sharp, lancinating quality of pain into the left arm. Pain in the last week is rated as 9 out of 10 on the pain scale. At times, he wakes up with his arms and hands completely numb. He is also having increasing jaw pain with yawning in addition to pain on the contralateral left side of the neck which has typically been predominantly right sided and with a knot like formation with intense spasming at times, which limits his ability to perform even very basic chores around his property. Avinza augmented by Norco in coordination with Botox injections has typically been sufficient such that he is able to perform basic chores until recent flaring. He has not had Botox for several months, and it will be requested. There is limited flexion of the cervical spine not greater than 48-50 degrees. He has difficulty flexing greater than 8 degrees right and 6 degrees left. He extends the neck no more than 46 degrees. There is exquisite subjective tenderness to palpation along the left splenius capitus, semi capitus, left occipitalis, left levator scapulae, left trapezius, left masseter, and left TMJ. Magnetic Resonance Imaging of the cervical spine dated 04/28/2014 documents there is C4-C5 level severe bilateral

neural foraminal narrowing secondary to uncovertebral osteophyte formation, which is unchanged to a lesser degree, and the findings are similar at C6-C7. The recommendation was for a C7-T1 Interlaminar epidural steroid injection with catheter spread to the C4 level, which the injured worker declines. The treatment plan includes refilling of Avinza and Norco, continued use of Docusate for constipation, a surgical consultation, which the injured worker will consider, and a follow up visit for reevaluation. Treatment requested is for Avinza 30mg #30, Botox 100 units (to be administered in physician's office), and Norco 10/325mg #90.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Botox 100 units (to be administered in physician's office): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin (Botox) Pages 25-26. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Botulinum toxin (injection). ODG - Low Back - Botulinum toxin (Botox).

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses Botox Botulinum toxin. MTUS Chronic Pain Medical Treatment Guidelines indicates that Botox Botulinum toxin is not generally recommended for chronic pain disorders. Botox is not recommended for tension-type headache, migraine headache, fibromyositis, chronic neck pain, myofascial pain syndrome, trigger point injections. Cervical dystonia is a condition that is not generally related to workers compensation injuries (also known as spasmodic torticollis). Official Disability Guidelines (ODG) indicates that Botulinum toxin injection is not recommended for mechanical neck disorders, whiplash, headache, fibromyositis, chronic neck pain, myofascial pain syndrome, or trigger point injections. Several recent studies have found no statistical support for the use of Botulinum toxin A (BTX-A) for the treatment of cervical or upper back pain, including myofascial analgesic pain, myofascial cervical pain, and myofascial trigger points. Recent systematic reviews have stated that current evidence does not support the use of BTX-A trigger point injections for myofascial pain or mechanical neck disease. There are potentially significant side effects including death. A boxed warning now highlights the possibility of experiencing potentially life-threatening distant spread of toxin effect from the injection site after local injection. Official Disability Guidelines (ODG) notes that there is currently insufficient scientific evidence of the effectiveness of botulinum toxin in the treatment of back pain. There are potentially significant side effects including death. A boxed warning now highlights the possibility of experiencing potentially life-threatening distant spread of toxin effect from the injection site after local injection. MRI magnetic resonance imaging of the cervical spine dated 4/28/14 demonstrated intervertebral fusion at C5-6. The progress report dated 01-05-2015 documented extremely limited range cervical range of motion throughout all planes of movement. Tenderness to palpation was noted along the corrugator supercilii, frontalis, procerus, temporalis, bilateral masseters, bilateral trapezius, splenitis capitis, levators, occipitalis and the bilateral greater occipital nerve distribution. With the patient's permission,

200 units of Botox was provided over the above-described muscle groups. The progress report dated 02-02-2015 documented that the patient had minimal help from the Botox injections. The patient reported that he had minimal help from the Botox injections, which he finds frustrating. The patient is continuing to describe pain which is largely through the frontalis which is primarily through the area of the procerus muscular distribution as well as through the orbits and with the patient describing posterior pain which would be through the frontal sinuses which have worsened. The headaches have become increasingly more debilitating. On the physical findings, the patient is extremely limited with cervical range of motion throughout all planes of movement. He remains tender through the bilateral cervical accessory musculature and directly over procerus and the periorbital regions. The diagnosis was chronic multifactorial cervical pain with a chronic industrial based migraine headache history. The progress report dated 04-06-2015 documented subjective complaints of cervical pain and pain into the left arm. He states that he often awakens with his arms and hands completely numb. On the physical findings, the patient is limited with flexion of the cervical spine, not greater than 48 to 50 degrees. He has difficulty flexing greater than 8 degrees right, 6 degrees left. He extends the neck no more than 46 degrees beyond neutral position. Subjective tenderness to palpation was noted along the left splenius capitis, semi capitis, left occipitalis, left levator scapulae, left trapezius, left masseter, left TMJ temporomandibular joint. To lesser degree, there was pain on the contralateral right trap, right sternocleidomastoid, procerus, comigator supercillii, frontalis, and bilateral temporalis. No tremor of nuchal muscles was noted. No involuntary contractions of multiple neck muscles were noted. Cervical pain with radiculopathy was noted. Botox injections were requested. The location of the Botox injection were not specified. The progress report dated 01-05-2015 documented that 200 units of Botox was provided over the "above-described muscle groups." The progress report dated 02-02-2015 documented that the patient had minimal help from the Botox injections. No objective evidence of functional improvement was documented. No objective evidence of improved physical examination findings were documented. The progress report dated 04-06-2015 documented a request for Botox injections. The location of the Botox injection was not specified. Because the location of the Botox injection was not specified, the 4/6/15 request for Botox injections cannot be endorsed. MTUS, ACOEM, and ODG guidelines do not support the request for Botox. Therefore, the request for Botox is not medically necessary.

**Avinza 30mg #30:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids: criteria for use, specific drug list.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page 74-96.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines (page 89) present the strategy for maintenance for long-term users of opioids. Do not attempt to lower the dose if it is working. Supplemental doses of break-through medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain. Actual maximum safe dose will be patient-specific and dependent on current

and previous opioid exposure, as well as on whether the patient is using such medications chronically. The progress report dated 01-05-2015 documented extremely limited range cervical range of motion throughout all planes of movement. Tenderness to palpation was noted along the corrugator supercilii, frontalis, procerus, temporalis, bilateral masseters, bilateral trapezius, splenius capitis, levators, occipitalis and the bilateral greater occipital nerve distribution. The progress report dated 02-02-2015 documented that the patient is continuing to describe pain which is largely through the frontalis which is primarily through the area of the procerus muscular distribution as well as through the orbits and with the patient describing posterior pain which would be through the frontal sinuses which have worsened. The headaches have become increasingly more debilitating. On the physical findings, the patient is extremely limited with cervical range of motion throughout all planes of movement. He remains tender through the bilateral cervical accessory musculature and directly over procerus and the periorbital regions. The diagnosis was chronic multifactorial cervical pain with a chronic industrial based migraine headache history. The pain center progress report dated 04-06-2015 documented subjective complaints of cervical pain and pain into the left arm. He states that he often awakens with his arms and hands completely numb. Low risk for opioid abuse was noted. Avinza and Norco have provided benefit. Activities of daily living are improved with medications. The 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors) were reviewed. On the physical findings, the patient is limited with flexion of the cervical spine, not greater than 48 to 50 degrees. He has difficulty flexing greater than 8 degrees right, 6 degrees left. He extends the neck no more than 46 degrees beyond neutral position. Subjective tenderness to palpation was noted along the left splenius capitis, semi capitis, left occipitalis, left levator scapulae, left trapezius, left masseter, left TMJ temporomandibular joint. To lesser degree, there was pain on the contralateral right trap, right sternocleidomastoid, procerus, corrugator supercilii, frontalis, and bilateral temporalis. No tremor of nuchal muscles was noted. Cervical pain with radiculopathy was noted. MRI magnetic resonance imaging of the cervical spine dated 4/28/14 demonstrated intervertebral fusion at C5-6. Medical records documented objective evidence of pathology on MRI magnetic resonance imaging studies. Medical records document objective physical examination findings. Medical records document regular physician clinical evaluations and monitoring. The request for Avinza is supported by clinical practice guidelines. Therefore, the request for Avinza is medically necessary.

**Norco 10/325mg #90:** Overtaken

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids: criteria for use, specific drug list.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page 74-96.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines (page 89) present the strategy for maintenance for long-term users of opioids. Do not attempt to lower the dose if it is working. Supplemental doses of break-through medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain. Actual maximum safe dose will be patient-specific and dependent on current

and previous opioid exposure, as well as on whether the patient is using such medications chronically. The progress report dated 01-05-2015 documented extremely limited range cervical range of motion throughout all planes of movement. Tenderness to palpation was noted along the corrugator supercilii, frontalis, procerus, temporalis, bilateral masseters, bilateral trapezius, splenitis capitis, levators, occipitalis and the bilateral greater occipital nerve distribution. The progress report dated 02-02-2015 documented that the patient is continuing to describe pain which is largely through the frontalis which is primarily through the area of the procerus muscular distribution as well as through the orbits and with the patient describing posterior pain which would be through the frontal sinuses which have worsened. The headaches have become increasingly more debilitating. On the physical findings, the patient is extremely limited with cervical range of motion throughout all planes of movement. He remains tender through the bilateral cervical accessory musculature and directly over procerus and the periorbital regions. The diagnosis was chronic multifactorial cervical pain with a chronic industrial based migraine headache history. The pain center progress report dated 04-06-2015 documented subjective complaints of cervical pain and pain into the left arm. He states that he often awakens with his arms and hands completely numb. Low risk for opioid abuse was noted. Avinza and Norco have provided benefit. Activities of daily living are improved with medications. The 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors) were reviewed. On the physical findings, the patient is limited with flexion of the cervical spine, not greater than 48 to 50 degrees. He has difficulty flexing greater than 8 degrees right, 6 degrees left. He extends the neck no more than 46 degrees beyond neutral position. Subjective tenderness to palpation was noted along the left splenius capitis, semi capitis, left occipitalis, left levator scapulae, left trapezius, left masseter, left TMJ temporomandibular joint. To lesser degree, there was pain on the contralateral right trap, right sternocleidomastoid, procerus, corrugator supercilii, frontalis, and bilateral temporalis. No tremor of nuchal muscles was noted. Cervical pain with radiculopathy was noted. MRI magnetic resonance imaging of the cervical spine dated 4/28/14 demonstrated intervertebral fusion at C5-6. Medical records documented objective evidence of pathology on MRI magnetic resonance imaging studies. Medical records document objective physical examination findings. Medical records document regular physician clinical evaluations and monitoring. The request for Norco 10/325 mg is supported by clinical practice guidelines. Therefore, the request for Norco 10/325 mg is medically necessary.