

<b>Case Number:</b>	CM15-0010792		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	08/25/2003
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2015

### 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: Utah, Arkansas  
 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 41 year old female, who sustained an industrial injury on 8/25/03. She has reported upper extremity and back injury. The diagnoses have included bilateral neurovascular thoracic outlet syndrome, status post Hemocyte autograft injection, serotonin syndrome (resolving), left knee strain with synovitis, bilateral pectoralis minor syndrome, right cubital tunnel syndrome, cervical dystonia and muscle spasms of back. Treatment to date has included Botox injections, oral medications, physical therapy and topical and transdermal medications. Currently, the injured worker complains of daily migraines, pain in sacrococcyx area with sitting and pain in chest and arms upon standing. Physical exam dated 1/31/15 noted her symptoms were worse in past week or two after the Botox had worn off and upon standing she almost immediately has a migraine. On 1/14/15 Utilization Review non-certified Botox for headache, noting previous treatment without documentation of treatment or improvement; ultrasound for thoracic outlet syndrome, noting it is recommended for thoracic outlet syndrome, however clinical suspicion for thoracic outlet syndrome is not clearly documented and bed with gatch, noting the injured workers condition does not require special positioning. The MTUS, ACOEM Guidelines and ODG were cited. On 1/15/15, the injured worker submitted an application for IMR for review of Botox for headache, ultrasound for thoracic outlet syndrome and bed with gatch.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Botox for Headache:** 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin, Page 25. .

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Botox.MTUS guidelines state the following: Not recommended for the following: tension-type headache; migraine headache; fibromyositis; chronic neck pain; myofascial pain syndrome; & trigger point injections. According to the clinical documentation provided and current MTUS guidelines; Botox is not indicated as a medical necessity to the patient at this time.

**Ultrasound for Thoracic Outlet Syndrome:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder, Arterial Ultrasound TOS testing.

**Decision rationale:** MTUS treatment guidelines are silent with regards to the above request. Other guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Ultrasound Testing for TOS. Guidelines state the following: Not recommended. According to the clinical documentation provided and current guidelines; Ultrasound Testing for TOS is not indicated as a medical necessity to the patient at this time.

**Bed with Gatch:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back

**Decision rationale:** MTUS treatment guidelines are silent with regards to the above request. Other guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for a bed with gatch. Guidelines state the following: Mattress Selection, not recommended to use firmness as sole criteria. The clinical documents lack documentation that the patient requires positions of the body in ways not feasible in an ordinary bed. According to the clinical documentation provided and current guidelines; a bed with gatch is not indicated as a medical necessity to the patient at this time.

