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| Case Number: | CM15-0172375 | | |
| Date Assigned: | 09/14/2015 | Date of Injury: | 06/11/1997 |
| Decision Date: | 10/13/2015 | UR Denial Date: | 08/27/2015 |
| Priority: | Standard | Application Received: | 09/01/2015 |

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: 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:

This is a 65-year-old male worker who was injured on 6-11-1997. The medical records reviewed indicated the injured worker (IW) was treated for cervical disc herniation; lumbar disc herniation; and facet syndrome. The progress notes (8-19-15) indicated the IW had 10 out of 10 neck pain and 8 out of 10 left shoulder pain with associated pain in the left forearm, wrist and hand; 5 out of 10 lower back pain; 5 out of 10 left elbow pain; and 7 out of 10 headache pain with blurred vision. Medications included Ibuprofen, Neurontin, Topamax, Provigil, Prestiq, Oxycontin, Nuvigil and Norco. Medications improved his pain by 90%. The IW was considered 100% disabled. On physical examination (7-22-15 and 8-19-15) there was tenderness and decreased range of motion to the left shoulder. Spasms were present in the bilateral cervical paraspinal muscles. There was tenderness to the temporomandibular joint (TMJ) and point tenderness of the paracervical and facet capsules on deep palpation at C2-C3 and C3-C4. Myofascial pain was noted in the area of the C3-C4 and C4-C5 facet capsules with spasm, triggering and ropey fibrotic banding bilaterally. Myofascial pain was also noted in the lumbar spine L3-L4, L4-L5 and L5-S1 regions with triggering and spasm. Treatments have included occipital nerve blocks (4-2012), with some relief; spinal surgeries; and cervical facet nerve blocks and radiofrequency rhizotomies with 75% improvement in headache pain (October of unknown year). Six trigger point injections were given (8-19-15) for severe pain. The documentation did not state the frequency and duration of the IW's headaches. A Request for Authorization dated 8-19-15 was received for an evaluation for Botox injections and retrospective review for trigger point injections (date of service 8-19-15). The Utilization Review

on 8-27-15 non-certified the request for an evaluation for Botox injections, as ODG has negative guideline recommendations for this treatment; trigger point injections (date of service 8-19-15) were non-certified due to lack of documentation of the presence of a twitch response.

IMR ISSUES, DECISIONS AND RATIONALES

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

Evaluation for Botox Injections: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Botulinum toxin (Botox Myobloc).

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 torticollis), 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 other anticholinergic 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. It does not have the indication for low back pain per the ACOEM. Therefore the request is not medically necessary.

Retrospective DOS: 8/19/15 Trigger Point Injections QTY: 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

Decision rationale: The California chronic pain medical treatment guidelines section on trigger point injections states: Trigger point injections: Recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. Not recommended for radicular pain. A trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Trigger points may be present in up to 33-50% of the adult population. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. (Graff-Radford, 2004) (Nelemans-Cochrane,2002) For fibromyalgia syndrome, trigger point injections have not been proven effective. (Goldenberg, 2004) Criteria for the use of Trigger point injections: Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. (Colorado, 2002) (BlueCross BlueShield, 2004) The provided clinical documentation fails to show circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. Therefore criteria have not been met and the request is not medically necessary.