

<b>Case Number:</b>	CM15-0074554		
<b>Date Assigned:</b>	04/24/2015	<b>Date of Injury:</b>	02/11/2010
<b>Decision Date:</b>	05/21/2015	<b>UR Denial Date:</b>	04/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/20/2015

### 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: 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:

The injured worker is a 60-year-old female, who sustained an industrial injury on 02/11/2010 complaining of injury to right knee, right elbow and whip lash of the neck as a result of a fall. On provider visit dated 03/18/2015 the injured worker has reported neck pain. On examination of the cervical spine revealed left paraspinous tenderness and stiffness. Palpable twitch positive points are noted in the muscles of the head and neck was noted to have a decreased range of motion with pain was noted. The diagnoses have included cervical spondylosis, muscle spasm and other pain disorder related to psychological factors. Treatment to date has included physical therapy, medication and surgical intervention. The provider requested physical therapy for the cervical spine and right shoulder 2 times a week for 6 weeks and Botox trigger point injections at the right trapezial area

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the cervical spine and right shoulder 2 times a week for 6 weeks:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**Decision rationale:** The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The goal of physical therapy is graduation to home therapy after a certain amount of recommended sessions. The patient has already completed a course of physical therapy. The request is in excess of these recommendations per the California MTUS. There is no explanation why the patient would not be moved to home therapy after completing the recommended amount of supervised sessions. Therefore the request is not medically necessary.

**Botox trigger point injections at the right trapezial area:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Botulinum toxin (Botox, Myobloc).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines botulism toxin Page(s): 26.

**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 otheranticholinergic 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. Per the California MTUS it does not have the indication in the treatment of other diagnosis. Therefore, the request is not medically necessary.