
Notice of Independent Medical Review Determination

Dated: 9/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	5/15/2013
Date of Injury:	4/10/2013
IMR Application Received:	5/22/2013
MAXIMUS Case Number:	CM13-0000452

- 1) MAXIMUS Federal Services, Inc. has determined the requested Botox injection 50 units **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested eight sessions of physical therapy for right and left temporomandibular joint dysfunction **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 5/22/2013 disputing the Utilization Review Denial dated 5/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/18/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 3) MAXIMUS Federal Services, Inc. has determined the requested Botox injection 50 units **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the requested eight sessions of physical therapy for right and left temporomandibular joint dysfunction **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Neurology, and is licensed to practice in California. 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 treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated May 15, 2013

" This clinical review is for a claimant who developed a headache syndrome after a trauma in April 2013. The chronic headache syndrome has not been associated with an abnormal physical exam or neurological exam. This claimant has been treated with oral narcotic medications. There is no data which documents any conservative therapy or any results of imaging."

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review (dated 5/22/2013)
- Utilization Review from [REDACTED] (dated 5/15/2013)
- Medical Records from Dr. [REDACTED] dated 4/10/13-6/6/13)
- Medical Records from [REDACTED] (dated 4/17/13)
- Medical Records from [REDACTED] (dated 5/1/13)
- Medical Records from Dr. [REDACTED] (dated 6/19/13)
- Medical Records from [REDACTED] (dated 6/25/13-7/26/13)
- Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments pgs 25-26

1) Regarding the request for Error! Reference source not found.:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), pg. 25-26, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on April 10, 2013 to the head, right knee and neck. The medical records provided for review indicate a diagnosis of chronic headache syndrome. The medical report of June 6, 2013 documents the employee continues to have dizziness daily, and nausea. The employee continues to have significant restricted activities of daily living. Treatments have included narcotic pain medication and anti-nausea medication. The request is for Botox injection 50 units.

The MTUS Chronic Pain guidelines indicate that Botox is not generally recommended for chronic pain disorders, tension-type headache, or migraine headaches. The injections are considered reasonable and necessary for dystonia. The medical records provided for review do not indicate that the employee dystonia. The request for Botox injection, 50 units, is not medically necessary and appropriate.

2) Regarding the request for eight session of physical therapy for right & left temporomandibular joint dysfunction:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator cited no evidence-based guidelines for its decision. The provider did not dispute the absence of the evidence-based guidelines by the Claims Administrator. The Expert Reviewer cited the Chronic Pain Medical Treatment Guidelines (May, 2009), pg. 99, which is a part of the Medical Treatment Utilization Schedule (MTUS), as relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on April 10, 2013 to the head, right knee and neck. The medical records provided for review indicate a diagnosis of chronic headache syndrome. The medical report of June 6, 2013 documents the employee continues to have dizziness daily, and nausea. The employee continues to have significant restricted activities of daily living. Treatments have included narcotic pain medication and anti-nausea medication. The request is for eight sessions of physical therapy for the right and left temporomandibular joint dysfunction.

The MTUS Chronic Pain guidelines state that physical medicine treatment frequency should decrease over time from three visits per week to one or less with the goal of a self-directed home exercise program. The medical records provided for review indicate the employee has already undergone seven physical therapy visits from June 26, 2013 through July 26, 2013, but there was lack of documentation showing functional improvement. There is no documentation about physical functional deficits to support the need for physical therapy. The request for eight sessions of physical therapy for the right and left temporomandibular joint dysfunction is not medically necessary and appropriate.

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.