MAXIMUS Federal Services

| Case Number: | CM13-0045663 | | |
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| Date Assigned: | 12/27/2013 | Date of Injury: | 08/25/2006 |
| Decision Date: | 04/22/2014 | UR Denial Date: | 10/28/2013 |
| Priority: | Standard | Application Received: | 11/12/2013 |

## 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

## 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 54 year-old female sustained an injury on 8/25/06 while employed by [redacted]. A report dated 9/15/13 stated that the patient was status post right medial branch radiofrequency neurotomy on 8/9/13; however, she has persistent symptoms not adequately controlled in her low back, seed bones, perineum, vagina, clitoris, right medial thigh, and pubic rim. Medications include Percocet, Aleve, and Tylenol. Exam revealed modest pain on facet loading with hyperextension, stress negative; allodynia to knee and top of thigh; dramatic pain pelvic loading, and SI maneuvers or direct pressure of pelvic rim. Treatment included Botox and to repeat pudendal and genitofemoral nerve blocks. The report from obstetrics & gynecology on 12/20/12 noted that the patient was with a history of chronic back and pelvic pain after a kindergartener head-butted her in the right lower quadrant and right hip bone. Diagnostic laparoscopy in November 2007 showed normal pelvic anatomy with dense adhesions around the appendix; she underwent appendectomy in December 2007 with normal pathology. An MRI of the pelvis in August 2009 was negative, and the abdominal x-ray in September 2010 was negative. Her diagnoses included atrophic vagina; she was started on a trial of estrace cream as she has been post-menopausal for 1.5 years without history or symptoms of pelvic organ prolapse or urinary incontinence. The patient is status post fallopian tube ligation in 1997 with history of abnormal PAP 10 years prior; however, this has been normal. There was mention of a history of sexual abuse per another gynecological provider; pelvic exam was stopped per patient's discomfort. Diagnoses of the visit were chronic pelvic pain and dyspareunia, and atrophy of the vagina. The plan was to continue with pelvic floor physical therapy and continue with pain management. The comprehensive report from 10/31/12 from a neurologist noted normal motor, sensory, reflexive exam; limited pelvic/groin exam; and tender right side of pubic bone. Review documented multiple other specialists of gynecologist and neurologists from

various sectors, including several universities, noting no deficits or clinical findings, unable to formulate any working diagnosis to explain for significant persistent inexplicable radiating symptoms with any anatomical accuracy. There have been multiple unremarkable MRIs (lumbar, pelvic, etc.) and bone scans along with numerous sympathetic blocks (pudendal and genitofemoral nerves), RF neurotomy, and lumbar injections with conflicting, and at times contradictory, evidence of improvement while causing her increasing symptoms. It was also noted that the patient has diagnosis of complex regional pain syndrome, but no classic findings were present. Recommendations included evaluation by gynecologist and/or urologist specializing in female anatomy at the university level, and also for psychiatric evaluation for possible conversion disorder. The current request for Botox was non-certified on multiple occasions.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**BOTOX INJECTIONS, 200 UNITS, UNDER EMG GUIDANCE FOR PELVIS PAIN RELATED TO COMPLEX REGIONAL PAIN SYNDROME OF THE RIGHT PELVIS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 25-26.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**Decision rationale:** The Official Disability Guidelines state that Botox injections are not generally recommended for chronic pain disorders, but may be recommended for cervical dystonia and possible chronic low back pain. The ODG is silent on the effectiveness of Botox for pelvic pain from complex regional pain syndrome. Review of multiple reports reveals no clear diagnoses, no remarkable clinical exams except for subjective tenderness, and no significant findings from extensive diagnostics. Multiple specialists from various practices including universities were unable to formulate any working diagnosis to explain for the persistent radiating symptoms without anatomical correlation. Submitted reports from the provider have not adequately demonstrated the indication or medical necessity for yet another injection after most recent failed radiofrequency neurotomy one month prior. Without clear specific indication to support for request, medical necessity has not been established. The request is not medically necessary and appropriate.