

Case Number:	CM15-0106414		
Date Assigned:	06/10/2015	Date of Injury:	09/30/2002
Decision Date:	07/13/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/02/2015

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: Montana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 46 year old female, who sustained an industrial injury on September 30, 2002. The injured worker was diagnosed as having thoracic outlet syndrome, spinal cord stimulator implant, cervical dystonia/myofascial pain, piriformis syndrome, major depression, chronic daily headache syndrome and migraine variant with dizziness and vertigo. Treatment to date has included Botox chemodenervation, spinal cord stimulator, trigger point injection and medication. A progress note dated May 4, 2015 provides the injured worker complains of worsening gluteal pain radiating down the legs. She requests trigger point injections and repeat piriformis Botox chemodenervation. She also has chronic migraines. Lastly her battery for the spinal cord stimulator is old and not holding the charge. Physical exam notes she appears to be in distress and ambulates with a cane. There is gluteal tenderness and painful straight leg raise. The plan includes spinal cord battery replacement, piriformis trigger point injections, piriformis Botox chemodenervation and medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Sided Piriformis Botox Chemodenervation Under Ultrasound Guidance As An Outpatient: Overturned

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(s): 25-26. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Botulinum toxin Spinal Healthcare and WebMD, Botox injection for piriformis syndrome.

Decision rationale: The MTUS does not specifically address piriformis syndrome but states that botulinum toxin (Botox; Myobloc) is 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: (1) 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) (2) Myofascial analgesic pain relief as compared to saline. (Qerama, 2006) (3) Use as a specific treatment for myofascial cervical pain as compared to saline. (Ojala, 2006) (Ferrante, 2005) (Wheeler, 1998) (4) 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 ODG guidelines state that there is a lack of high quality studies evaluating BoNT injections for patients with low back pain. Among the studies that exist, there is significant heterogeneity in trial design and outcome parameters. The current body of evidence does not support the use of BoNT injections to improve pain or function in patients with low back pain. Spinal Healthcare and various other web-based sites note that Botox injections are a secondary treatment option for piriformis syndrome. In this case the injured worker has intractable pain with the use of a spinal cord stimulator and maximum pain medications. The records note that she did have significant benefit from Botox injections of the piriformis bilaterally in 2013. With

a favorable initial response, the request for Right Sided Piriformis Botox Chemodenervation Under Ultrasound Guidance As An Outpatient is medically necessary.