

<b>Case Number:</b>	CM15-0184604		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	10/25/2013
<b>Decision Date:</b>	11/02/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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 51 year old male who sustained an industrial injury on 10/25/2013. Medical records indicated the worker was treated for lumbar disc displacement without myelopathy, thoracic or lumbosacral neuritis or radiculitis, unspecified radicular syndrome and sciatica, and pain in joint involving the pelvic region and thigh, arthralgia, buttock and femur. Treatments have included epidural steroid injections (date not given) and ultrasound guided steroid injection to the left piriformis, and left buttock trigger point injections (06-29-2015) by a pain management physician. A MRI on 02-13-2015 was read with the impression of mild lumbar spondylosis; no disc protrusions or extrusions; and no significant foraminal or central canal stenosis. In the provider notes of 08-12-2015, the injured worker complains of ongoing pain in the posterior portion of the left lower leg. He stated the piriformis injections and left buttock trigger point injections gave about 5 days of significant symptomatic relief, but after five days, his symptoms returned. The worker describes pain as sharp and stabbing and localized in the left buttock areas. He intermittently has pain and burning that radiates down the entire posterior aspect of his left leg into the calf area. The pain is worse with prolonged sitting or squatting. He describes his baseline level of pain as a 5 on a scale of 10 and escalating to a 9 on a scale of 10 with extended and prolonged exertion or sitting. He uses no assistive device to walk, and does not complain of any new weakness in the lower extremities. His medications include Ibuprofen and Gabapentin. On exam, the worker has no visible abnormalities of the paraspinal muscles. There is a solitary trigger point along the left lower paraspinal area and focal moderate to severe tenderness to palpation over the left piriformis muscle. His range of

motion of the lower extremities is full and straight leg raise is negative bilaterally. Treatment plans included Botox injections in the buttock area and piriformis injections followed by physical therapy. The worker is currently not working. A request for authorization was submitted for a Left Buttocks Botox injection and Physical Therapy following Botox injection, 6 visits. A utilization review decision 08/19/2015 non-certified both requests.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Left Buttocks Botox injection: 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): 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.

**Physical Therapy following Botox injection, 6 visits: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Physical Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**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 requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. There is no objective explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. The request is not medically necessary.