

<b>Case Number:</b>	CM15-0034826		
<b>Date Assigned:</b>	03/03/2015	<b>Date of Injury:</b>	10/05/2007
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	02/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2015

### 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 59 year old female, who sustained an industrial injury on 10/5/07. She has reported back injury lifting a carton weighing 33 pounds. The diagnoses have included incontinence, urgency, lumbar disc herniation, lumbar spinal stenosis, lumbar radiculopathy and back pain. Treatment to date has included medications, surgery, diagnostics, acupuncture, chiropractic, physical therapy, psychological evaluation, and lumbar Epidural Steroid Injection (ESI). Surgeries included status post partial corpectomy with arthrodesis 4/15/09, lumbar laminectomy and foraminotomy 3/2010 and bladder pacemaker implanted 10/21/13. Currently, per the physician progress note dated 1/23/15, the injured worker complains of discomfort and pain over the hardware. She is limited in activities of daily living (ADL's) due to pain. The physical exam of the lumbar spine revealed tenderness to palpation over the hardware. The physician recommended removal of the hardware. She denies any urinary complications at this time. As cited by the utilization review, physician progress note dated 7/29/14, which was not present in the documentation, noted that the injured worker complained of urinary incontinence requiring 6 protective pads per day. She has had a recent kidney infection and has had severe incontinence since having lumbar surgery. She states that since implantation of the bladder pacemaker device, she feel she stimulation on the right side of the perineal and vaginal areas and the urinary symptoms are 50 percent improved. She has continued urgency and incontinence with laughing. She was treated with Myrbetriq daily and multiple anticholinergics with minimal improvement in symptoms. Physical exam as cited revealed normal urethral position and no vaginal vault prolapse. The renal ultrasound was normal. Recommendation was for Botox

injections 100 units into the bladder. On 2/17/15 Utilization Review non-certified a request for Continue Botox injections 200 units (bladder), noting the non- (MTUS) Medical Treatment Utilization Schedule Clinical Policy Bulletin was cited.

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

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

**Continue botox injections 200 units (bladder): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Clinical Policy Bulletin.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines botulism injection.

**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. Per the California MTUS it does not have the indication in the treatment of other diagnosis. Therefore the request is not certified.