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| <b>Case Number:</b>   | CM15-0035920 |                              |            |
| <b>Date Assigned:</b> | 03/19/2015   | <b>Date of Injury:</b>       | 03/19/2008 |
| <b>Decision Date:</b> | 04/20/2015   | <b>UR Denial Date:</b>       | 02/18/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/25/2015 |

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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:

This 58-year-old female sustained an industrial injury to the low back on 3/19/08. Previous treatment included epidural steroid injections, magnetic resonance imaging scans, physical therapy and medications. In a PR-2 dated 1/26/15, the injured worker complained of ongoing low back pain, rated 7-9/10 on the visual analog scale with bilateral lower extremity radicular symptoms. Physical exam was remarkable for lumbar spine with tenderness to palpation in the paraspinal muscles with restricted range of motion. Current diagnoses included low back pain and status post L5-S1 epidural steroid injection with minimal benefits. The treatment plan included continuing medications (Ibuprofen 800mg and Tramadol 50mg), a Botox injection for the lumbar spine, 8 sessions of physical therapy and a urine drug screen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Botox Injections 400 units for lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin Page(s): 25-26.

**Decision rationale:** According to MTUS guidelines, Botulinum toxin is not generally recommended for chronic pain disorders, but recommended for cervical dystonia. See more details below. 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 typeA (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) In this case, the patient has a chronic low back pain with a history of epidural steroid injections with minimal relief. Botulinum toxin is not generally recommended for chronic pain disorders, but recommended for cervical dystonia. It is not recommended for migraine headache, tension headache, chronic neck pain, trigger point injection, and myofascial pain. In addition, there is no indication that the patient is participating in a functional restoration program. Cited guidelines recommend the use of Botox injections in conjunction with functional restoration program. Therefore, the request for 1 Botox Injections 400 units for lumbar spine is not medically necessary.

**8 sessions of physical therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**Decision rationale:** According to MTUS guidelines, Physical Medicine is 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) There is no documentation of the efficacy and outcome of previous physical therapy sessions. The patient underwent physical therapy between April 17, 2013 and May 30, 2013 without clear documentation of efficacy. There is no documentation that the patient cannot perform home exercise. Therefore, the request for 8 physical therapy sessions is not medically necessary.