Case Number:	CM14-0210314		
Date Assigned:	12/23/2014	**Date of Injury:**	11/16/2012
Decision Date:	02/20/2015	**UR Denial Date:**	12/06/2014
Priority:	Standard	**Application Received:**	12/15/2014

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:

The patient is a 37-year-old man who sustained a work injury on November 16, 2012. He subsequently developed chronic low back pain. The patient had a left L4-5 laminectomy in 2012 and had physical therapy that was beneficial. On October 10, 2014, the patient had a left L5-S1 transforaminal epidural steroid injection. . Lumbar MRI dated December 26, 2013 showed L4-5 left laminotomy defect with epidural enhancing fibrosis in the left lateral recess. No evidence of recurrent herniation or stenosis. L5-S1 degenerative changes with relatively broad-based right posterior disc protrusion mildly narrowing right lateral recess and right neural foramen. EMG/NCV showed L5-S1 radiculopathy. According to the progress note dated November 17, 2014, the patient continued with persistent low back pain with radicular symptoms down his left lower extremity. He stated that the epidural injection was quite helpful; however, days before his visit, he has had some significant flare up of his back pain. His average pain was a 6/10. On examination, the patient had decreased range of motion in the lumbar spine as well as tenderness to palpation of the paraspinal muscles. he was able to walk without any significant antalgic gait. The patient was diagnosed with low back pain radiating to the left lower extremity and status post left L4-L5 laminectomy and discectomy on December 20, 2012. The provider requested authorization to use Botox 400 unit injection into lumbar spine paraspinal musculature.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Botox 400 unit injection into lumbar spine paraspinal musculature: 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 < 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 summary and according to MTUS guidelines, 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 myofacial pain. Therefore, Botox 400 unit injection into lumbar spine paraspinal musculature is not medically necessary.