Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 2/20/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of one visit of a psoas compartment plexus block with Botox chemodenervation under fluoroscopic guidance with 5 Botox chemodenervation injections with EMG guidance (64640, 77003, 64614, 95874, J0585, 99144, 99145, A4550, A4649).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The reviewer is a Medical Doctor who is board certified in Anesthesiology.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of one visit of a psoas compartment plexus block with Botox chemodenervation under fluoroscopic guidance with 5 Botox chemodenervation injections with EMG guidance (64640, 77003, 64614, 95874, J0585, 99144, 99145, A4550, A4649).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD: Pain Institute Follow-up Exam Notes – 8/30/11-1/12/12, Rehab Script & Pain Drawing and Visual Analog Scale – 5/12/11, Physical Rehab Daily Note – 4/12/11, Operative Reports – 6/8/11 & 11/10/11; and MD EMG & NCV Findings Report – 4/6/11.

Records reviewed from: Denial Letters – 1/16/12 & 1/23/12; LHL009 – 2/3/12; Pain Institute Pre-auth Request – 1/16/12, Reconsideration Request – 1/23/12

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant is a male who is reported to have sustained work related injuries on xx/xx/xx. No early historical records or information on mechanism of injury were submitted for review. The claimant reports low back pain radiating into the bilateral lower extremities. He reports pain and stiffness without relief with Ultracet. He reports relief with Botox chemo denervation. The patient reports several weeks of relief with lumbar intraspinal injections. On physical exam, he's reported to have a forward flexed posture and antalgic gait with limited range of motion of the lumbar spine. He's reported to have some tenderness to the quadratus lumborum, gluteus maximus and gluteus medius. He has tenderness across the lower back going down the left lower extremities to the toes. He had give way strength secondary to pain. He's reported to have failed back syndrome. Dr. opines that the claimant has iliopsoas dysfunction and a myofascial pain syndrome at the paraspinal muscles and gluteal region and he recommends the claimant undergo left psoas compartment plexus bock with Botox chemo denervation under fluoroscopic imaging with Botox under EMG guidance. He was provided trigger point injections and given toradol 60mg intramuscularly. He was switched back to hydrocodone and given cyclobenzaprine. EMG/NCV study dated 04/06/2011. It's noted that the claimant has diabetes, mild axonal type abnormalities in the perineum nerves with some temporal dispersion and left peroneal and denervation findings mostly in the mid paraspinals suggestive of a neuropathy possibly related to the patient's diabetes and also suggestive of bilateral mid lumbar radiculopathy. EMG showed peroneal neuropathy, diabetic neuropathy, and possible lumbar radiculopathy. The patient was seen in 1/12 and had forward flexed posture and tenderness in the lumbar spine and gluts. Botox had been done before with 'several weeks' of relief, no details given.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

ODG low back chapter: Botulinum toxin (injection)
Under study. This lower quality study found that botulinum toxin type A showed clinical usefulness in pain reduction and for functional improvement in patients with sacroiliac joint pain, and for a longer time than a mixture of triamcinolone and lidocaine injection. (Lee, 2010)
Botulinum toxin (Botox; Myobloc)
Not generally recommended for chronic pain disorders, but recommended for cervical dystonia. See more details below.
Not recommended for the following: tension-type 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 (BTX-A) for any of the following (note, most reference links go to Neck Chapter):

- 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)

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 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 worker's 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. See the Neck Chapter for cervical dystonia references.
Recommended: urinary incontinence following spinal cord injury. Botox significantly reduced urinary incontinence and improved urodynamics and quality of life in spinal cord injury and multiple sclerosis patients with neurogenic detrusor overactivity. (Cruz, 2011) Botulinum toxin is well tolerated and provides clinically beneficial improvement for urinary incontinence and neurogenic detrusor overactivity secondary to spinal cord injury or multiple sclerosis. (Herschom, 2011) There are other potential roles in spinal cord injury with spasticity. (Marciniak, 2008)
Recommended: spasticity following TBI. See the Head Chapter.
Under study: 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) See also Low Back Chapter.
Under study: migraine headache. The evidence is mixed for migraine headaches. This RCT found that 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 migraine and chronic tension-type headache (Level B). (Naumann, 2008) The FDA approved Botox injection having a history of migraine and experiencing a headache on most days

of the month. (FDA, 2010) It is recommended as a second line therapy (since other acute therapies should have been attempted).
Psoas blocks Recommended as an option after one month physical therapy trial.

The request for psoas compartment plexus block with Botox chemo denervation under fluoroscopic guidance with Botox chemo denervation injections with EMG guidance is not supported as medically necessary. The record contains no significant historical data imaging studies, procedure reports or other information to establish the medical necessity of the request. The record contains a single note indicating that the claimant has myofascial pain and potential evidence of a radiculopathy. There is no indication that the claimant has undergone a trial of physical therapy. The patient had botox before with less than a month of benefit. Botox should last 3 months to be considered therapeutic. While botox is now supported by ODG for back pain, the patient's response to it is subtherapeutic so does not warrant repeating. In addition, there is no necessity for EMG guidance for this procedure.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**