

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.

DATE OF REVIEW: February 2, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

One visit of eight Botox chemodenervation with EMG guidance

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

American Board of Psychiatry and Neurology in Psychiatry, and American Board of Pain Medicine

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Carrier include:

- Institute, 02/06/06, 05/24/06, 11/28/06, 12/21/06
- Services, 12/18/06
- 12/29/06, 01/02/07, 01/03/07, 01/04/07, 01/09/07, 01/10/07
- , 05/16/06

Medical records from the Requestor include:

- Institute, 02/06/06, 04/04/06, 05/09/06, 06/29/06, 09/05/06, 10/05/06, 11/16/06, 11/28/06, 12/21/06
- 07/20/06
- Institute, 01/25/07

PATIENT CLINICAL HISTORY:

The patient has a history of multiple body aches and pains from "repetitive motion injury." Required medical examination finds nonphysiologic total body pain.

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

There is no documented cervical dystonia. In cases of cervical dystonia, Botox injections are sometimes considered reasonable and necessary. Clinical documentation supports generalized myofascial pain that is predominantly nonphysiologic. Medical necessity for 8 Botox chemodenervation injections cannot be established.

**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)