

**C-IRO, Inc.**  
**An Independent Review Organization**  
**7301 Ranch Rd 620 N, Ste 155-199**  
**Austin, TX 78726**  
Phone: 512-266-5815

Notice of Independent Review Decision

**DATE OF REVIEW:** SEPTEMBER 1, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Piriformis Injections w/botox, with 5 botox injections-Lumbar

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

Board-certified in Internal Medicine and specialized in Occupational 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**

Notification of Case Assignment, Medical Records from Requestor, Respondent, Treating Doctor (s), including:  
Denial Letters-August 6, 2007, July 30, 2007  
Dr. August 2006 to July 2007  
MRI right hip, August 2006

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant injured her lower back when a patient fell on top of her. MRI of the right hip showed a small effusion. No other diagnostic testing is provided. The claimant carries a diagnosis of piriformis syndrome. She had improvement after a previous botox injection, but details regarding this improvement are not provided. Physical examination findings to support the diagnosis of piriformis syndrome are not provided.

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

The Reviewer has reviewed the applicable guidelines and the peer-reviewed medical literature concerning botox injections in the treatment of chronic piriformis syndrome. This modality has been shown to provide good relief of symptoms in this syndrome (sometimes for up to a year) when other treatment methods have failed. After a careful of the medical records, it is not clear from the records provided how the diagnosis of piriformis syndrome was obtained. Given this diagnostic uncertainty, this treatment cannot be approved.

**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)**