

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: MAY 16, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Botox injections to multiple sites of the left thoracic paraspinous and supraspinous muscle

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that Botox injections to multiple sites of the left thoracic paraspinous and supraspinous muscle are medically necessary for this patient.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 5/2/08, 4/29/08
MD, 5/7/08, 4/21/08, 1/30/08, 9/28/07, 9/14/07, 5/31/07, 4/12/07, 3/28/07, 12/18/06,
11/15/06, 10/30/06, 7/24/06, 5/5/06, 4/21/06, 1/20/06
MD, 4/3/07
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured on XX/XX/XX and since has been suffering from bilateral upper back pain. She has been managed with Botox injections since 05/04/2001. It is noted that she typically receives significant relief (more than 90%) for 4-6 months each time she receives this treatment. This allows her to work full-time and also not require any medications to manage her pain.

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

The *Official Disability Guidelines* do not recommend Botox injections for anything but cervical dystonia. However, in this situation, this patient receives significant pain relief of approximately 90% or better every time she receives this procedure. In addition, the pain relief lasts approximately 4-5 months. Given that this patient is able to work full-time and not require any medications after this treatment, the reviewer is diverging from the ODG guidelines in this case. Using both my medical judgment and my clinical experience, I find this treatment, Botox injections to multiple sites of the left thoracic paraspinous and supraspinous muscle, to be medically necessary for this patient.

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)**