

CORE 400 LLC
240 Commercial Street, Suite D
Nevada City, California 95959

DATE OF REVIEW: FEBRUARY 12, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Office visit for diagnostic myofascial mapping

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

MD, Board Certified in Anesthesiology and Pain Management

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 medical necessity does not exist for Office visit for diagnostic myofascial mapping.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 1/9/09, 1/16/09
Dr. MD, 1/26/09, 12/29/08, 12/1/08, 11/3/08, 10/6/08, 7/14/08
MRI of Cervical Spine, 8/18/06
Dr. MD, 9/21/06
Behavioral Evaluation, 7/21/06
emails and internal correspondence, 2008-2009
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx year old reportedly developed neck pain after her xx hit a bump. The date of injury is listed as xx/xx/xx. The material stated she had degenerative changes in her cervical spine and subsequently underwent a C5-6 and C6-7 fusion in 2005. This was extended to include C3-4 and C4-5 in 2007 when an MRI showed foraminal stenosis at these levels. She continued to have neck pain, headaches and muscle spasm. An EMG in 2006 showed bilateral C5 radiculopathy and carpal tunnel syndrome. There are comments of Botox injections in 2005.

There are requests for EMG mapping for Botox injections. There are several notes describing neck pain attributed to spasmodic torticollis, a form of cervical dystonia. There is a note in the record dated 1/18/09 in which Dr. is reported to have acknowledged that this patient does not have cervical dystonia.

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

The patient is diagnosed with myofascial pain. The use of Botox for myofascial pain is based upon anecdotal "off label" use of the medication. The ODG does not approve the use of Botox for treatment of myofascial neck pain. This is based upon the lack of evidence based medicine studies. Botox is approved for the treatment of cervical dystonia, however the doctor in this case has acknowledged that this patient does not have cervical dystonia. The patient does not meet the guidelines. The reviewer finds that medical necessity does not exist for Office visit for diagnostic myofascial mapping.

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 KNOWLEDGBASE
- 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)**