

Notice of Independent Review Decision

DATE OF REVIEW: 01/13/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

One visit of eight Botox chemodenervation injections of 100 units with EMG Guidance

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

The TMF physician reviewer is board certified in anesthesiology/pain management with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the one visit of eight Botox chemodenervation injections of 100 units with EMG Guidance is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 12/31/08
- Utilization review determination letter from – 11/13/08
- Reconsideration/Appeal of adverse determination letter from . – 11/25/08
- Follow up examinations by Dr. – 11/14/06 to 11/04/08
- Letter from attorneys to – 01/06/09
- Copy of ODG Treatment Guidelines for Low Back – Lumbar & Thoracic (Acute & Chronic)
- Article from Neurology, 2000 May 6;70(19):1707-14

- Article from Neurology, 2001 May 22;56(10):1290-3
- Article from Clin J Pain, 2002 Nov-Dec;18(6 Supp):S155-G2
- Article from , 2004 Mar;83(3):198-2002
- Decision letter from – 11/12/08
- Preauthorization Request from – 11/17/08
- Response letter from Dr. – 11/17/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx resulting in injury to his back with pain to the lower back and lower extremities. The patient has been treated with a spinal cord stimulator as well as Botox chemodenervation injections. The treating physician is requesting that the patient undergo repeat Botox chemodenervation injections.

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

Botox is considered experimental for back pain and spasms. There are some studies which show some efficacy but no studies are large enough to warrant the conclusion that Botox is effective. In addition there are no studies that support EMG guidance for Botox injections. Therefore, it is determined that the ODG guidelines do not support Botox injections as medically necessary.

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)