



IMED, INC.

1701 N. Greenville Ave. • Suite 202 • Richardson, Texas 75081
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 09/15/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Chemodeneration of muscle(s); extremity(s) and/or trunk muscle(s)
(EG, for dystonia, cerebral palsy, multiple sclerosis)

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

Texas Board Certified Orthopedic Surgeon

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Office note from , M.D., , 01/03/08, 01/24/08
2. Rehabilitation referral, 06/04/08, 07/02/08
3. MRI left elbow without contrast, 01/18/08
4. Lateral release for left elbow chronic epicondylitis 02/15/08
5. Operative report for repair of lateral collateral ligament and repair of extensor communis tendon 05/08/08
6. Office notes for Dr. , 05/04/09, 06/30/09, , 07/06/09
7. Previous peer review reports dated 06/12/09 and 07/08/09
8. Items in dispute, chemodeneration of muscles; extremities and/or trunk muscles (EG, for dystonia, cerebral palsy, multiple sclerosis), 06/16/09, 07/08/09
9. Correspondence letter from the employee, , 07/30/09
10. ***Official Disability Guidelines***

PATIENT CLINICAL HISTORY (SUMMARY):

We begin with office notes with Dr. , orthopedic surgeon, on 01/03/08. At that time, it was noted that the employee had recurrent levels of pain and discomfort within the left elbow sphere. She had received multiple Cortisone shots and recurrent pain every

three to four months within the left elbow. Treatment at that time included Kenalog and Xylocaine injections at the elbow. Further recommendation was to proceed with an MRI for evaluation and follow-up after the MRI.

An MRI of the left elbow was obtained on 01/18/08. This revealed a minimal joint effusion, medial and lateral epicondylitis with partial tear of the common flexor and extender tendon, and distal biceps tendinosis and minimal bicipital bursitis.

On 02/15/08, the employee underwent a lateral release of the chronic lateral epicondylitis of the left elbow. There were no major perioperative complications discussed.

The following medical record was an additional operative intervention on 05/08/08. This was an operative for repair of lateral collateral ligament and repair of extensor communis tendon. There were no noted perioperative complications.

There appears to be a gap in the medical records with an office visit occurring on 05/04/09. At that time, it was noted that the employee was being followed for bilateral lateral epicondylitis to the elbow. She complained of pain described as 6 on the Wong-Baker scale and involved both elbows. She did have quite noticeable dystonia of the biceps muscle. The muscle was taut to touch and had markedly increased tone. She was unable to fully extend the elbow due to muscle tightness. She was counseled in regard to receiving muscle blockade of the biceps, as well as the ECRL and ECRB. Two muscle blockades were given, one in the biceps and one between the ECRL and ECRB muscles. She tolerated the procedure well with some gentle active range of motion afterwards. She was able to extend the elbow. Level of pain was 2/10 and a 1 on the Wong-Baker scale. It was opined that the patient's dystonic activity in the muscle would benefit from chemical denervation on an outpatient basis. Authorization would be obtained. The impression was right and left lateral epicondylitis with focal dystonia in the biceps muscle bilaterally, as well as ECRL and ECRV. The recommendation was to try to obtain approval for chemical denervation for dystonic activities to the biceps and ECRL and ECRV muscles bilaterally. The prognosis for return to work was good with projected return to limited duty or full duty. She was currently working full duty. The employee was to follow-up in ten days to two weeks. This office note was from Dr. ,

Follow-up occurred on 06/30/09 with Dr. . It was not noted whether the employee was given additional blockades on that date or of the previous blockades that were given. It was noted that the chemical denervation had been denied. The recommendation was to continue to obtain approval. She was given a Flector patch, Zanaflex, Ultram ER, Cymbalta 60 mg po daily and was to follow-up in two weeks.

Prior peer reviews were reviewed from 06/12/09 and 07/08/09. Previous determination for chemical denervation showed a non-approval for this modality given the lack of evidence for conservative treatment measures post office visits in 2008 and office visits in 2009. There was a large gap in medical treatment noted without evidence of clear conservative treatment measures. It was also apparent that injury occurred on xx/xx/xx, although there was no mechanism of injury submitted in the current medical documentation. Intervention occurred on the left elbow; however, the current request for chemical denervation included the bilateral elbows. The use of chemical denervation in the **Official Disability Guidelines** is not supported.

An on-line article was reviewed in Springer Link for botulinum toxin Type A for treatment of bicep/triceps co-contraction and obstetrical brachial plexus lesions. This is a very small study consisting of six children presenting with severe bicep/triceps co-contracted after nerve regeneration of an obstetrical brachial plexus lesion. Botulinum toxin injections were monitored by ENG recordings. There was good response to these injections. Additional thorough literature search for clinical studies supporting the use of botulinum toxin treatment in the setting of dystonia revealed a paucity of good clinical studies available for review.

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

Based on the current evidence based medicine guidelines in the Official Disability Guidelines, on-line edition, in both the Elbow Chapter and Pain Chapter, the use of chemical denervation in this setting is simply not supported. There is a paucity of good clinical studies supporting use at this time, and although this employee does appear to receive temporary benefit from steroid/anesthetic injection into these areas, chemical denervation using botulinum toxin injection is not indicated at this time using evidence based medical guidelines. Decision is to uphold the denial for this procedure. Determination is to deny.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

1. *Official Disability Guidelines*, Neck, Low Back, Shoulder and Pain Chapters, Online Version