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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/11/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat Botox 700 units injection x 1, office procedure

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

MD, Board Certified Physical Medicine and Rehabilitation 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines-Treatment for Worker's Compensation, Chapter: Pain Utilization review determinations dated 01/25/11, 02/08/11

Exam notes dated 03/03/11, 07/08/10, 03/23/10, 12/17/09, 07/30/09, 07/01/09, 04/08/09, 12/18/08, 12/08/08, 09/10/08, 08/19/08, 03/27/08, 01/10/11, 09/29/10

Clinician sheet dated 03/07/11, 01/10/11, 08/12/10, 04/27/10, 07/19/10, 10/13/09

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xxxx. The earliest clinical record is an office visit note dated 03/27/08. The patient presents for Botox injections and underwent injections to the bilateral hamstring, bilateral posterior tibial muscle, and bilateral gastroc muscles. Follow up note dated 08/19/08 indicates that the patient's chief complaint is spasticity and Botox injections in March 2008 helped with the spasticity. The patient underwent repeat Botox injections on 09/10/08, 12/18/08. Note dated 07/01/09 indicates that the patient has spinal cord injury with spastic paraparesis most prominently in the bilateral lower extremities. The patient underwent Botox injections on 07/30/09, 12/17/09, 04/27/10, and 08/12/10. Follow up note dated 09/29/10 indicates the patient's chief complaint is gait difficulty. The patient was ill with pneumonia and colitis. He then developed some back pain radiating to the leg. There is some weakness to the quadriceps muscles and he has increased spasticity as well. Initial request for Botox injection was non-certified on 01/25/11 noting that there is no documentation of improvement in function or decrease in VAS pain scores that would support additional injections. There is no updated physical therapy provided for review to support continued use of Botox. The denial was upheld on appeal on 02/08/11 noting that there is no recent clinical assessment from a treating physician with detailed subjective and objective findings that substantiate the necessity of the request. Also, ODG limits the recommendation of the requested modality to specific conditions such as cervical dystonia.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

This patient sustained injuries over xx years ago. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient has undergone multiple Botox injections; however, the patient's objective, functional response to these injections is not documented to establish efficacy of treatment and support additional injections. There is no current, detailed physical examination submitted for review. The Official Disability Guidelines support Botox injections for treatment of cervical dystonia, and there is no indication that the patient presents with cervical dystonia. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. The reviewer finds there is no medical necessity for Repeat Botox 700 units injection x 1, office procedure.

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

ACOEM-AMERICA 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)