

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/20/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Botox 200 units to left trapezius

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

M.D., Board Certified Anesthesiology/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 medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the requested Botox 200 units to left trapezius is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Request for IRO dated 07/13/12

Utilization review determination 06/29/12

Utilization review determination 07/16/12

Clinical records

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who. The claimant is status post cervical fusion. The claimant has undergone permanent implantation of intrathecal drug delivery device, which provides 70% relief. The patient presents for refill of his pump and to obtain new prescriptions for Lortab 10 mg, Skelaxin 800 mg. He is noted to be status post cervical discectomy and fusion x 4 with Synchroned replacement. On physical examination he is well developed and well nourished. He is noted to be deaf. He has a well healed scar in his right anterior neck. He has decreased extension and left lateral rotation. There is spasm of the splenius cervicis and left trapezius with trigger and radiation of pain to left upper extremity scapula. He is noted to have decreased sensation in left at C7 and C8. Motor strength is 4/5. He is noted to have severe spasm of left trapezius with triggering to left scapula and left arm. Trigger point injections of left trapezius are suggested. The claimant was seen in follow-up on 07/09/12. He presents for refill of pump. He reported 60-65% relief for use of his pump. He is reported to have continued headache, neck stiffness, no numbness and tingling or weakness in arms or hands. The patient had Botox 200 units injected into trapezius, which provided him 5 months of relief. The claimant's intrathecal pump was refilled. Dr. non-certified the request noting that Botox is not generally recommended for chronic pain disorders but is recommended for cervical dystonia. She notes the patient has radiculopathy on examination,

which is contraindication to performance of trigger point injections of any type and notes Botox is not supported for myofascial pain. The appeal request was reviewed on 07/16/12. The reviewer upheld the previous denial noting the claimant has a history of cervical fusion. The claimant is reported to have a history of spasmodic torticollis. Physical examination is unremarkable and provides no findings suggestive of recurrent spasmodic torticollis. There is no data to indicate the claimant has exhausted lower levels of conservative care.

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

The available clinical record indicates that this claimant has a history of cervical pain status post fusion. He is noted to have reduced cervical range of motion and chronic pain. Physical examination suggests presence of residual radiculopathy, which is contraindication of performance of trigger point. No specific trigger points are identified within the clinical record. In addition to this, Botox is clinically indicated for treatment of spasmodic torticollis. However, the records do not indicate the claimant has recurrent development of torticollis. Therefore, it is the opinion of the reviewer that the requested Botox 200 units to left trapezius is not medically necessary.

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)