

SENT VIA EMAIL OR FAX ON  
Dec/22/2011

## **P-IRO Inc.**

An Independent Review Organization  
1301 E. Debbie Ln. Ste. 102 #203  
Mansfield, TX 76063  
Phone: (817) 405-0878  
Fax: (214) 276-1787  
Email: resolutions.manager@p-iro.com

### **NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE OF REVIEW:**  
Dec/22/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Botox once a year every 3 months

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**  
Board Certified PM&R  
Subspecialty: Pediatric Rehabilitation

**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**

OD Guidelines

1. Cover sheet and working documents
2. Utilization review determination 11/18/11, 12/07/11
3. Office visit 11/07/11, 08/17/11, 05/11/11, 06/13/11, 07/15/11, 10/03/11
4. Follow up note Lone Star Imaging 05/09/11
5. MRI cervical spine 10/14/10
6. Texas Workers' Compensation work status report 10/03/11, 11/07/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. The majority of the submitted medical records are poor copies and exceedingly difficult to interpret. On the date of injury the patient was involved in a motor vehicle accident when her car was struck by a truck which pushed her car over an embankment. MRI of the cervical spine dated 10/14/10 revealed mild

multilevel disc bulges/protrusions with very mild multilevel neural foraminal stenosis; no compression fractures, minimal posterior bony osteophyte formation, minimal wedging of T3, T4, and perhaps T5 vertebrae. Follow up note dated 06/29/11 indicates that the patient reports excellent results from her cervical epidural steroid injection with no residual arm pain. Follow up note dated 11/07/11 indicates that the patient complains of pain localized to the neck. Treatment to date is noted to include cervical epidural steroid injection x 2, trigger point injections in cervical area, NSAIDs and medication management. On physical examination cervical alignment is normal and shoulder is leveled. There is tenderness in the cervical paraspinals and parascapular muscles. Range of motion is decreased 30% in flexion, extension, and lateral bending of the cervical spine. Spurling's test is negative. Motor is listed as 5/5 in bilateral upper and lower extremities with the exception of 4/5 left WE, finger abduction. Sensation is intact.

Initial request for Botox once a year every 3 months was non-certified on 11/18/11 noting that there is no evidence of true torticollis or cervical dystonia in this case which is the indication for Botox cervical injections. The denial was upheld on appeal dated 12/07/11 noting that per ODG guidelines, Botox is recommended for cervical dystonia, but not for mechanical neck disorders including whiplash.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

Based on the clinical information provided, the request for Botox once a year every 3 months is not recommended as medically necessary, and the two previous denials are upheld. The submitted records fail to establish that the patient presents with true torticollis or cervical dystonia as required by the Official Disability Guidelines for the performance of Botox injections. ODG does not support Botox injections for mechanical neck disorders including whiplash. Given the current clinical data, the requested Botox injections are not indicated as 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)