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Notice of Independent Review Decision

DATE OF REVIEW: 1/2/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of left trapezius Botox injections (D) 64614.

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

The reviewer is a Medical Doctor who is board certified in Anesthesiology. The reviewer has been practicing for greater than 5 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of left trapezius Botox injections (D) 64614.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: The and Hospital.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 10/14/11 office notes by MD, 8/31/11 letter by 9/21/11 letter by Dr. 4/12/11 established patient note by MD, 11/18/11 denial letter, 12/5/11 letter by 11/30/11 letter by Dr. and 12/8/11 denial letter.

Hospital (FCH): 11/23/10 to 3/22/11 office notes by DO, 11/23/10 to 3/22/11 progress notes by Dr. office notes by Dr. 4/7/11 to 11/14/11, cervical MRI report

3/15/11, left shoulder MRI report 3/15/11 and a Clinical impression sheet dated 6/15/11 (unsigned).

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. The mechanism of injury was patient struck by an 80lb door. The submitted records indicate that the patient was determined to have reached MMI by a designated doctor as of 11/02/10 with 5% whole person impairment. Note dated 04/12/11 indicates that the patient underwent recent myelogram. The treating physician noted that he told the patient that he does not think there is anything he can do for him given the lack of structural reason for his symptoms. Note dated 10/14/11 indicates that the patient sustained head injury. Medications include Lyrica, Flexeril and Norco. The records from the Neurosurgeon recommend that the patient see a neurologist for possible Botox injection. MRI of cervical spine, dated 03/15/2011 shows mild central canal stenosis at C5-6 and C6-7 related to small disc protrusions. MRI of left shoulder dated 03/15/2011 showed intact rotator cuff and mild AC joint DJD.

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

According to the ODG Neck and upper back Chapter Botulinum toxin (injection) is recommended for cervical dystonia, but not recommended for mechanical neck disorders, including whiplash.

They are not recommended for the following: headache, fibromyositis; chronic neck pain, myofascial pain syndrome; and trigger point injections. Several recent studies have found no statistical support for the use of Botulinum toxin A (BTX-A) for the treatment of cervical or upper back pain, including the following:

1. Myofascial analgesic pain relief as compared to saline.
2. Use as a specific treatment for myofascial cervical pain as compared to saline.
3. Injection in myofascial trigger points as compared to dry needling or local anesthetic injections.

Recent systematic reviews have stated that current evidence does not support the use of BTX-A trigger point injections for myofascial pain (Ho, 2006) or for mechanical neck disease (as compared to Saline). There is one recent study that has found statistical improvement with the use of BTX-A compared to saline. Study patients had at least 10 trigger points and no patient in the study was taking an opioid. Botulinum toxin A (e.g. Botox) remains under study for treatment of chronic whiplash associated with disorders and no statistical difference has been found when compared to treatment with placebo at this time.

Botulinum injections are recommended for cervical dystonia, a condition that is not generally related to workers' compensation injuries, and is characterized as a movement disorder of the nuchal muscles, characterized by tremor or by tonic posturing of the head in a rotator, twisted or abnormally flexed or extended position or some combination of these positions. In recent years, Botulinum toxin A has become first line therapy for cervical dystonia. When treated with BTX-B, high antigenicity limits long-term efficacy. Botulinum toxin A injections provide more objective and subjective benefit than trihexyphenidyl or other anticholinergic drugs to patients with cervical dystonia.

Based on the clinical information provided there is no documentation of cervical dystonia (torticollis). The neurological exam is normal. The left trapezius muscle is in spasm and is painful to palpation. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no current, detailed physical examination submitted for review. These symptoms do not justify a Botulinum toxin injection at this time. Therefore, the requested service is found to be not medically necessary at this time.

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)**