MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-2250-01
Name of Patient:	
Name of URA/Payer:	State Office of Risk Management
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	A.T. Carrasco, MD

August 30, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in neurology. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Robert Partain, MD
A.T. Carrasco, MD
Texas Workers Compensation Commission

CLINICAL HISTORY

Documents reviewed included: Texas Workers' Compensation Commission documents; Multiple progress notes and evaluation sheets from Dr. A.P. Carrasco; Multiple procedure notes including lumbar epiduralography, steroid injections, left piriformis injection, electromyography done by A. Roman, MD 2/9/2000; neurosurgical evaluation on Ms. ___ done by Robert Partain, III, MD 2/21/1995; operative report of Botox chemodenervation with EMG guidance for needle localization total of eight sites with intravenous sedation by A.P. Carrasco, MD 2/9/2000.

An approximate 47-year-old female with a work related back injury ___. Multiple conservative treatments. Status post several lumbar epidural steroid injections. She has been on multiple medications. The patient did show improvement after Botox chemodenervation of the bilateral quadratus lumborum, bilateral gluteus medius, and bilateral gluteus maximum muscles in February 2000. There was temporary improvement for several months. The patient is also status post spinal cord stimulator placement. The patient has had increasing trigger point tenderness in the quadratus lumborum, gluteus, medius and gluteus maximum. Request for repeat chemodenervation.

REQUESTED SERVICE(S)

Botox Chemodenervation injections, one visit of eight injections with EMG guidance.

DECISION

Approved for Botox chemodenervation with EMG guidance for needle localization total of eight sites.

Intravenous sedation is denied.

RATIONALE/BASIS FOR DECISION

The previous usages of the botulinum toxin type A chemodenervation was helpful for several months. The usage of this treatment for this type of pain has been very helpful in multiple pain syndromes. This was indeed helpful for this patient. The amount of botulinum toxin used previously was reasonable. It is felt, however, that intravenous sedation is absolutely not needed for this type of procedure.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 31st day of August 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell