

MATUTECH, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 14, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Office visit (99214), trigger point injections (20553), and Zanaflex [medication] 2 mg one t.i.d. (J2795).

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

The physician providing this review is a physician, doctor of medicine. The reviewer is national board certified in physical medicine and rehabilitation. The reviewer is a member of American Academy of Physical Medicine and Rehabilitation. The reviewer has been in active practice for twenty-three years.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Partially Overturned (Agree in part/Disagree in part)

Medical documentation partially supports the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Department of Insurance

- RME (06/14/06)
- Utilization review (09/11/07)

M.D.

- Radiodiagnostics (05/21/03 – 09/26/03)
- Office notes (01/22/07 - 07/18/07)

- RME (06/14/06)
- Office note (07/18/07)
- Utilization review (09/11/07)

No guidelines provided.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a female who was injured on xx/xx/xx when she fell onto the concrete floor and developed head and neck pain.

No records from xxxx through 2002.

X-rays of the lumbar spine in 2003 revealed degenerative disc disease (DDD) at multiple levels and wedging of the anterior portion of the T12. Magnetic resonance imaging (MRI) of the lumbar spine revealed: (1) T12-L1: 40 degree superior plate compression fracture of the T12. An annular disc bulge at T12-L1 encroaching on the anterior epidural space. (2) L1-L2: Mild annular hypertrophy concentrically. (3) L3-L4: Anterior-superior plate Schmorl's node at L4 and retrospectively at L1. Mild concentric annular disc bulge. (4) L4-L5: right paramedian disc protrusion effacing the epidural space and extending into the lateral recess.

In 2006, M.D., performed a required medical evaluation (RME). *Following the injury, the patient was treated with therapy, vocational training, and work hardening. Currently, she was under care of M.D., for pain management and was being treated with medications, injections, and therapy.* Current medications included tizanidine and Lunesta. Dr. rendered the following opinions: (1) The patient had reached maximum medical improvement (MMI). She should be able to work in her current work environment as a cashier. (2) Although she had a herniated lumbar disc, these were late findings and probably not related to the original injury. (3) She did not require pain management treatment since August 2000. All of a sudden, the patient who had not required care in two years, needed care one time in 2002, four times in 2003, and then on a regular basis in 2004. For the first time, she required narcotic pain medication. There was an apparent injury in xx/xxxx. She would require twice a year evaluation of her chronic back situation and would need muscle relaxants. No sleep medication was related to the injury of xxxx. (4) There was no need for further diagnostics, procedural treatments, transcutaneous electrical nerve stimulation (TENS) unit, work conditioning/work hardening, or chiropractic manipulation.

In January 2007, Dr. noted: *the patient had been treated with psoas compartment blocks in 1996 with moderate relief, lumbar facet procedures x3 from 1999 through 2000 with 50% relief, lumbar ESI x2 with 50% relief for two weeks, and lumbar facet blocks x1 in 2004 with 20-30% relief.* On examination, trigger points were noted in the thoracolumbosacral region. Dr. performed multiple TPIs in the shoulder, posterior thoracic, abdominal area, posterior lumbar area, and pelvis and buttock regions. The patient was treated with myofascial release following the injections. In April and July, Dr. repeated the TPIs in the same regions and prescribed Zanaflex.

On September 11, 2007, the carrier issued a letter stating: *Received IRO*

request for denial services of office visit, TPIs, and medications. Carrier continues to stand by previous determination of the recommendation submitted by required medical evaluation (RME). The RME by Dr. states that no further medical treatment is medically necessary for the date of injury (xx/xx/xx). Therefore, reconsideration is being denied.

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

ACCORDING TO THE MEDICAL RECORDS DR. BOYLE DID SAY ONGOING TREATMENT WAS NECESSARY AS NOTED WHERE HE STATES "MEDICATIONS INCLUDING AN ANTI-INFLAMMATORY AND A MUSCLE RELAXANT" WERE REASONABLE. ALTHOUGH HE DID NOT RECOMMEND TPIS, ODG SPECIFICALLY STATES THAT IF MUSCLE RELAXANTS FAIL TO CONTROL SPASMS AND IF THERE IS NO RADICULAR COMPONENT THE TRIGGER POINTS CAN BE TRIED. TRIGGER POINT INJECTIONS SHOULD NOT EXCEED THREE TO FOUR INJECTIONS WITH A GREATER FREQUENCY THAN TWO MONTHS IF THERE IS 50% IMPROVEMENT OR BETTER. ODG FURTHER STATES USING ONLY A LOCAL ANESTHETIC WITH OR WITHOUT CORTICOSTEROIDS FOR SPASMS WITH MYOFASCIAL PAIN. AFTER REVIEWING THE RECORDS THERE IS NO DOCUMENTATION OF 50% IMPROVEMENT WITH TPIS, THE DIAGNOSES INCLUDES RADICULOPATHY AND I QUESTION THE RELATEDNESS GIVEN THE LOCATION. REGARDLESS, OF THE RELATEDNESS, TWO OF THE CRITERIA SET BY ODG WERE NOT MET AND THEREFORE NOT REASONABLE.

IN CONCLUSION, THE MUSCLE RELAXANT IS REASONABLE AND OFFICE VISITS TWICE A YEAR IS REASONABLE, BUT THE TPIS ARE NOT.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES