

SENT VIA EMAIL OR FAX ON  
Dec/07/2009

## True Decisions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Nov/30/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

PSOAS Compartment Plexus Block under Fluoroscopic Guidance; Destruction by neurolytic agent, other peripheral nerve or branch; Moderate sedation services provided by the same physician performing the diagnostic or therapeutic services that the sedation supports, first 30 minutes intra-service time; Moderate sedation services provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, additional 15 minutes intra-service time

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

Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management  
Subspecialty Board Certified in Electrodiagnostic Medicine  
Residency Training PMR and ORTHOPAEDIC SURGERY

**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)

PSOAS Compartment Plexus Block under Fluoroscopic Guidance are necessary

Trigger point injections cannot be justified

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Denial Letters 10/23/09 and 11/5/09

Pain 11/14/06 thru 10/7/09

Pain Institute 11/1/2000

**PATIENT CLINICAL HISTORY SUMMARY**

This is a man injured in xxxx. He has a spinal cord stimulator for pain. The 2000 initial note suggested this was not for a disc herniation, but was for somatic chronic pain. He had prior psoas Botox injections semiannually from 6/04-6/07 that reportedly helped. There is a request for additional psoas injection with trigger point injections. He has per Dr. , a left radiculopathy, facet hypertrophy, foraminal and central stenosis and myofascial pain. Dr. described "specific areas of active and reproducible trigger point tenderness noted to the quadratus lumborum, gluteus medius and gluteus maximus."

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

The ODG refers psoas blocks to piriformis blocks. It approves these, including botox injections when accompanied by therapy. The Reviewer did not see that this was added in the prior Botox injections. The ODG itself accepts Botox injections into the paraspinal muscles. There is limited evidence. The American Pain Society guidelines do not recognize evidence confirming (but neither is there evidence disproving) the effectiveness of Botox injections. The way the Reviewer interprets the ODG, it will approve the Botox injections as the prior ones were successful, however the man must be placed in a functional restoration program. This falls into pain programs in the ODG. The chronicity of the condition may exclude this person from being in such a program. Therefore, the Reviewer will concur that the Botox injection is appropriate provided the person is entered into a functional restoration program.

The second issue is the need for trigger point injections. There are several times that Dr. identified the presence of "...trigger point tenderness noted to the quadratus lumborum, gluteus medius and gluteus maximus." He had the diagnosis of myofascial pain syndrome. Travell and Simons wrote, as does the ODG, that trigger points are not just tender areas, but have associated twitch responses and referred pain. These were not described. For a further conflict, the ODG states that trigger point injections should not be performed when a radiculopathy is being treated. Dr. 's diagnosis cited the presence of a radiculopathy. Therefore trigger point injections cannot be justified.

**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)