



Medical Review Institute of America, Inc.
America's External Review Network

DATE OF REVIEW: July 31, 2009

IRO Case #:

Description of the services in dispute:

PSOAS Block with Fluoroscopy and 4–6 trigger point injections.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician providing this review is board certified in Anesthesiology and is a doctor of Osteopathy. The reviewer is currently an attending physician at a major medical center providing anesthesia and pain management services. The reviewer has participated in undergraduate and graduate research. The reviewer has been in active practice since 1988.

Review Outcome

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

Partially Upheld

The 4–6–trigger point injections are not supported as medically necessary since it is only in one note that the doctor indicates he has a twitch response with palpation.

PSOAS block with fluoroscopy is medically necessary after physical therapy has been attempted which in this case it has been done and the symptoms continue.

Information provided to the IRO for review

1. Records from state:

Letter from Texas Department of Insurance 7/13/09
Confirmation of Receipt of a Request for a Review
Company Request for IRO
Independent Review Organization License
Request for a Review by an Independent Review Organization
Utilization Review Determination 6/19/09

Reconsideration/Appeal Determination 7/9/09
Notice to MRloA 7/14/09
Notice to Utilization Review Agent of Assignment 7/14/09
Letter of Consideration from Pain Institute 6/10/09
Follow-up Examination from Pain Institute 4/7/09, 5/19/09

2. Records from Dr.

Follow-up Examination from Pain Institute 11/4/08

Patient clinical history [summary]

The patient is a male who sustained a work related injury in xx/xx. The patient has had prior back surgery and has a spinal cord stimulator in. He had botox to the lumbar and gluteal area in 7/08. This had worn off by 11/08. The doctor's note indicates trigger points with tenderness and a twitch response (mentioned once in the 6/09 note). He is requesting trigger point injections to the gluteal and a psoas injection with fluoroscopy. The patient has limited lumbar range of motion.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The patient has what appears to be PSOAS or piriformis syndrome based on her ongoing buttock pain with no evidence of radiculopathy. The PSOAS block is reasonable after physical therapy has been attempted which in this case it has been done and the symptoms continue. Fluoroscopy guidance is one method of doing this. However, the trigger point injections are not supported since it is only in one note that the doctor indicates he has a twitch response with palpation. Every other note only states tenderness. Also, the request is for 4-6-trigger point injections are in excess of ODG Guidelines.

A description and the source of the screening criteria or other clinical basis used to make the decision:

ACOEM Guidelines page 300, 309

ODG Guidelines: for Trigger Point Injections: Criteria for the use of Trigger point injections:

Trigger point injections with a local anesthetic with or without steroid may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAID's and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections

unless a greater than 50% pain relief with reduced medication use is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended; (9) There should be evidence of continued ongoing conservative treatment including home exercise and stretching. Use as a sole treatment is not recommended; (10) If pain persists after 2 to 3 injections the treatment plan should be reexamined as this may indicate an incorrect diagnosis, a lack of success with this procedure, or a lack of incorporation of other more conservative treatment modalities for myofascial pain. It should be remembered that trigger point injections are considered an adjunct, not a primary treatment.

For psoas block (ODG Guidelines links this with piriformis injection): Recommended for piriformis syndrome after a one-month physical therapy trial. Piriformis syndrome is a common cause of low back pain and accounts for 6–8% of patients presenting with buttock pain, which may variably be associated with sciatica, due to a compression of the sciatic nerve by the piriformis muscle (behind the hip joint). Piriformis syndrome is primarily caused by fall injury, but other causes are possible, including pyomyositis, dystonia musculorum deformans, and fibrosis after deep injections. Symptoms include buttock pain and tenderness with or without electrodiagnostic or neurologic signs. Pain is exacerbated in prolonged sitting. Specific physical findings are tenderness in the sciatic notch and buttock pain in flexion, adduction, and internal rotation (FADIR) of the hip. Imaging modalities are rarely helpful, but electrophysiologic studies should confirm the diagnosis, if not immediately, then certainly in a patient re-evaluation and as such should be sought persistently. Physical therapy aims at stretching the muscle and reducing the vicious cycle of pain and spasm. It is a mainstay of conservative treatment, usually enhanced by local injections. Surgery should be reserved as a last resort in case of failure of all conservative modalities. No consensus exists on overall treatment of piriformis syndrome due to lack of objective clinical trials. Conservative treatment (eg, stretching, manual techniques, injections, activity modifications, modalities like heat or ultrasound, natural healing) is successful in most cases. For conservative measures to be effective, the patient must be educated with an aggressive home-based stretching program to maintain piriformis muscle flexibility. He or she must comply with the program even beyond the point of discontinuation of formal medical treatment. Injection therapy can be incorporated if the situation is refractory to the aforementioned treatment program. Injections with steroids, local anesthetics, and botulinum toxin have been reported in the literature for management of this condition, but no single technique is universally accepted. Localization techniques include manual localization of muscle with fluoroscopic and electromyographic guidance, or ultrasound. The piriformis muscle, after localization with a digital rectal examination, can be injected with a spinal needle. Care should be taken to avoid direct injection of the sciatic nerve. (Papadopoulos, 2004) (Kuncewicz, 2006) (Huerto, 2007) See also Psoas blocks.