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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 09/03/2010

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified) doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

4 trigger point injections to the lumbar spine with CPT codes #20550, #99144, #99154, #A4550 and #99070 (20550 - injection-tendon sheath ligament, 99144 - moderate conscious sedation [IV] -corticosteroid, A4550 -surgical tray and 99070 - supplies)

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 12-16-08 Follow-up Examination from Dr.
- o 03-17-09 4 Follow-up Examinations reports from Dr. through October 1, 2009.
- o 03-20-09 Pre-authorization request - review from Dr.
- o 07-06-09 Request for authorization letter from Dr. for Botox injections
- o 07-14-09 Adverse Determination Review for Botox injections from MRI
- o 08-10-09 IRO Adverse Determination Report for Botox injections, unsigned
- o 08-20-09 Notice of Independent Review Decision
- o 02-09-10 Follow-up Examination report from Dr.
- o 04-06-10 Follow-up Examination report from Dr.
- o 06-03-10 Follow-up Examination report from Dr.
- o 07-20-10 Pain Management progress report from Dr.
- o 07-26-10 Utilization review report from MRI
- o 07-26-10 Adverse Determination Letter from
- o 08-03-10 Request for authorization and medical necessity from Dr.
- o 08-05-10 Letter notifying of receipt of request for services from
- o 08-09-10 Utilization review report on reconsideration from MRI
- o 08-09-10 Reconsideration - Adverse Determination Letter from
- o 08-16-10 Request for IRO from the Claimant
- o 08-17-10 Confirmation of Receipt of Request for IRO from TDI
- o 08-17-10 Notice to P&S of Case Assignment from TDI

PATIENT CLINICAL HISTORY (SUMMARY):

According to the medical records and prior reviews the patient is a male employee who sustained an industrial injury to the low back on xx/xx/xx.

The patient was reevaluated on December 16, 2008 for lower back and gluteal region pain. He has had intermittent flare-ups relieved with a small amount of medication. He continues to ride a bike and do HEP. He will be seen again in 3 months.

Request for outpatient psoas compartment plexus block was considered in review on March 20, 2009 with recommendation for certification. The provider was not available for peer calls. The case was discussed with the provider's nurse. The patient has a history of chronic back pain as well as right lower extremity pain. The patient has not had any surgeries. The nurse noted various pain generators such as disc bulging at L5-S1, facet mediated pain and pain/dysfunction in the right hip/psoas region with a myofascial component. She reported the patient had previous psoas block treatment in 2006, which provided good pain relief for the past few years, and a recent flare-up has occurred. His home program is not resolving the flare-up and he does not use much medication. The treatment is desired for better pain control and to help prevent increased use of medication and allow the patient to do his home exercises more effectively. ODG does not apply for psoas compartment plexus blocks. The reviewer cited Lang Clinical Anesthesiology, 4th edition, Chapter 17 regarding Peripheral Nerve Blocks which discusses blocks for regional anesthesia/surgical anesthesia. On this basis the request was certified.

Reevaluation of April 21, 2009 indicates the patient underwent a right psoas compartment plexus block with trigger point injections on March 25, 2009 and is reporting approximately 90% improvement with no muscle spasms since the injection. He will be seen again in two months. A physical examination was not reported for this visit.

Reevaluation of June 23, 2009 notes increased pain of several weeks duration. He previously received three weeks of good relief with trigger point injections. Assessment is pain to the lower back and lower extremities and right-sided radiculopathy. Recommendation is for a right psoas compartment plexus block with Botox chemodenervation under fluoroscopy and Botox chemodenervation injections with EMG guidance. A physical examination was not reported for this visit.

On July 6, 2009 the provider requested authorization for a psoas block with Botox for ongoing myofascial pain and development of "small fragments of muscle spasms" with localized areas of trigger points tenderness. The provider supports trigger point injections after other treatments have failed. Prior to injection of Botox he provides a trial of trigger point injections using a medium acting local anesthetic as well as steroids. The Botox acts to denervate the nerves chemically. EMG guidance is used to ensure proper location of the injection. The provider has extensive experience with these injections and has given seminars to other physicians. Botox results in control of pain secondary to muscle dysfunctions, as well as the release of muscle spasms.

Request for right psoas block with Botox and 5 Botox chemodenervation injections with fluoroscopy was considered in review on July 14, 2009 with recommendation for non-certification. A peer discussion was attempted but not realized. The claimant is a xx year-old male who has low back and leg pain. He has undergone several psoas compartment blocks, which provided medium-term relief, based on examination noting trigger points in the quadratus lumborum, the gluteus maximus and gluteus medius. According to ODG, Botox is not recommended for the treatment of pain in the lower back and legs. It is only recommended for pain associated with bona-fida cervical dystonia.

The patient returned on August 6, 2009. A psoas block of March 2009 provided complete relief of his symptoms for one month. He is now using Vicodin and Celebrex without relief. He has specific areas of active and reproducible trigger point tenderness noted to the quadratus lumborum, the gluteus maximus and gluteus medius. Recommendation is for a right psoas compartment plexus block under fluoroscopy and trigger point injections.

An IRO report dated August 10, 2009 indicates consideration was given for a right psoas block with botox and 5 botox chemodenervation injections with fluoroscopy with recommendation to uphold the prior non-certification. The provider diagnosed a psoas compartment syndrome and performed a local anesthetic block with steroid that gave 3 weeks of relief. He would like to inject this and the iliopsoas with Botox under fluoroscopy control. He would also like to inject the quadratus lumborum, the gluteus maximus and gluteus medius trigger points. A detailed description of Botox use in myofascial pain was provided. There was also a request to use the EMG to be sure of needle placement. The reviewer presumes that the fluoroscopy is used for the deeper iliopsoas and the EMG for the more superficial gluteal and quadratus muscles. ODG refers the reader to the piriformis injections at the site of the psoas blocks. It would appear that the intent was to discuss the need for initial therapy before the blocks. The examination discussion is specific for the piriformis muscle. There is no information provided by the physician regarding physical findings. Further, no evidence was found of a trial of conservative therapy. The ODG does consider the use of Botox for trigger point injections for back pain combined with therapy. The injections were in the paraspinus muscles and not the muscles and trigger points requested by the physician. While the narrative of the physician is educational, the request does not meet the criteria of evidence-based medicine cited in the ODG. Lacking this evidence and documentation of failed prior treatments, the procedure cannot be supported.

The patient was seen next on October 1, 2009. He has no trigger point tenderness this visit. He will be seen again in two months. A physical examination is not reported.

On February 9, 2010 the patient reported a flare-up that occurred over a week prior which he treated with exercises and medications. He walks approximately five miles daily. Assessment is patient with pain to the lower back and extremities and right-sided radiculopathy. He will return in 4 months. A physical examination is not performed this visit.

On March 17, 2010 the patient reports ongoing pain and discomfort and pain with ambulation. He has limited ROM at the right hip and specific areas of active and reproducible trigger point tenderness at the quadratus lumborum. He should undergo a right psoas compartment plexus block under fluoroscopic imaging to decrease pain and improve ROM and decrease medication intake (recommended or administered?).

Reevaluation notes of April 6, 2010 note a pain level of 1/10, good range of motion and intact gait in a patient with pain to the lower back and lower extremities. He is administered a Toradol (trigger point) 60 mg injection. He will return in 2 months.

The patient was seen in follow-up on June 3, 2010. He states he is doing well overall and describes a pain level of 1/10. He has good ROM and his gait is intact. He will continue with conservative care and continue to remain as active as possible. He will return in 3 months.

The patient was reevaluated on July 20, 2010. He reports an exacerbation of a week or so. He has mild to severe pain to the lower back. He has increased his hydrocodone and used Celebrex and performed HEP without relief. He has specific areas of active and reproducible trigger point tenderness noted to the quadratus lumborum, the gluteus maximus and gluteus medius. He has limited lumbar ROM secondary to pain. He will be placed in a rehab program for 3 x 3 to improve ROM and decrease pain. He is also recommended to undergo diagnostic and therapeutic trigger point injections with Marcaine and Kenalog to further relieve his pain. The patient was given a trigger point injection on this visit with Toradol injection 60 mg on this visit.

Request for injection(s); single tendon, sheath, or ligament, Aponeurosis (EG Plantar fascia)/four trigger point injections was considered in review on July 26, 2010 with recommendation for non-certification. A peer discussion was attempted but not realized. Per the reviewer, there was insufficient documentation submitted for review that demonstrated that this patient had participated in a recent and reasonable course of physical therapy. Per guidelines, radiculopathy must also not be present by exam, imaging or neurological testing. The clinical note of July 20, 10 noted reflex abnormality of left patella reflex of 2+ and right of 1+. Additionally, this patient received a trigger point injection on July 20, 2010 without sufficient documentation of the patient's response.

On August 3, 2010 the patient reported mild to severe lower back pain. He has increased his Hydrocodone and is using Celebrex and doing HEP without relief. Examination showed specific areas of active and reproducible trigger point tenderness noted the quadratus lumborum, the gluteus maximus and gluteus medius. With direct palpation there is twitch response noted with radiation of pain at the trigger point sites. Right patellar reflex is weaker than left. He has limited ROM with flexion and extension secondary to pain. He has an exacerbation of his pain. He will be placed in a rehab program for 9 visits. He is recommended to undergo diagnostic and therapeutic trigger point injections with Marcaine and Kenalog. Request is for 4 trigger point injections. He has had back pain for over 3 months. He has circumscribed trigger points. Stretching, exercises, PT and medications have failed to control his pain. He is using medications such as Hydrocodone, Celebrex and Skelaxin. Radiculopathy is not present by examination, imaging or neurotesting.

Request for reconsideration Injection(s); single tendon, sheath, or ligament, Aponeurosis (EG Plantar fascia) (4 trigger point injections) was considered in review on August 5, 2010 with recommendation for non-certification. A peer discussion was attempted but not realized. Per the reviewer, the request for 4 trigger point injections to the lumbar spine is not medically necessary. The clinical documentation indicates the patient has objective findings of trigger points with positive twitch response. The documentation also indicates the patient has had persistent low back pain for over 3 months and has been unresponsive to medication management and a home exercise program. The patient may benefit from trigger point injections at the time; however the patient would not require moderate sedation for these injections. As such, the medical necessity for the request for 4 trigger point injections to the lumbar spine with CPT codes #20550, #99144, #99154, #A4550 and #99070 has not been established at this time.

Request was made for an IRO.

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

Per ODG: The primary goal of trigger point therapy is the short-term relief of pain and tightness of the involved muscles in order to facilitate participation in an active rehabilitation program and restoration of functional capacity. These injections are not recommended for typical chronic low back or neck pain, nor are they recommended for radicular pain. The advantage appears to be in enabling patients to undergo remedial exercise therapy more quickly. TPIs are generally considered an adjunct rather than a primary form of treatment and should not be offered as either a primary or a sole treatment modality. Steroid injection is not generally recommended nor is Botulinum toxin. Criteria include, 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. It should be remembered that trigger point injections are considered an adjunct, not a primary treatment. Psoas blocks are supported after a one month physical therapy trial.

The patient is being treated for an injury of 10 years prior. He is seen 4-5 times a year for rechecks and generally maintains with medication and HEP. He rides a bike and can walk for 5 miles. He has intermittent flare-ups relieved with a small amount of medication. The patient was recommended 9 visits of active rehabilitation but there is no documentation that he has attended any recent formal therapy. The purpose of rehab is to restore the patient's functional capacity. The reports do not include much in the way of examination to indicate the patient's functional deficits. He appears to be treated primarily for pain. On April 6, 2010 the patient has a pain level of 1/10. He is provided a Toradol trigger point injection and on June 3, 2010 again has a pain level of 1/10. The rationale for a Toradol trigger point injection provided when he was doing well is not clear. On July 20, 2010 the patient was again provided a trigger point injection with Toradol injection 60 mg. The response to this injection is not reported.

There is some support for trigger point injections to the piriformis muscle in ODG. While the provider's proficiency in trigger point injections is appreciated, other causes of pain do not appear to have been ruled out. The patient does have a history of discogenic pain and facet pain according to the provider's nurse. A tight psoas is often the cause of lower back pain, knee pain and tightness in the hips and inner thighs. There are no specific examination findings to substantiate a psoas syndrome or that the patient has been instructed in psoas muscle stretches. The iliopsoas muscle is deep and not easily palpated and is more likely to be chronically shortened than have "small fragments of muscle spasms" or focal "trigger points." A person with active Quadratus Lumborum trigger points will typically experience severe pain when their trunk is in an upright position. Often they will instinctively brace and support their upper body with their arms to avoid this severe pain. A person with active Gluteus Medius trigger points will have pain during walking, and difficulty laying on their side while sleeping. The patient has also not been assessed for possible piriformis syndrome. The reevaluation reports do not include thorough physical examination findings to differentiate that the specific muscles desired for injection are in need of injections for focal trigger points versus being shortened and in need stretching. The patient's height and weight and posture are not reported and/or correlated with the muscle findings.

First line review denial rationale notes, reflex abnormality of left patella reflex of 2+ and right of 1+, indicating radiculopathy. Also, the patient received a trigger point injection on July 20, 2010 without sufficient documentation of the patient's response.

Second line review denial rationale notes the patient may benefit from trigger point injections; however the patient would not require moderate sedation for these injections.

Given the trigger point injections appear to be provided as the primary treatment and lack of description of the patient's response to the most recent injections, additional trigger point injections with moderate conscious sedation are not supported per ODG.

Therefore, my recommendation is to agree with the previous non-certification of the request for 4 trigger point injections to the lumbar spine with CPT codes #20550, #99144, #99154, #A4550 and #99070 (20550 - injection-tendon sheath ligament, 99144 - moderate conscious sedation [via IV] -corticosteroid, A4550 -surgical tray and 99070 - supplies)

The IRO's decision is consistent with the following guidelines:

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
- AHCP- 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

The Official Disability Guidelines 08-11-2010 Low Back Chapter - Trigger point injections (TPIs):

Not recommended in the absence of myofascial pain syndrome. See Criteria for use below. See the Pain Chapter for more information and references. The primary goal of trigger point therapy is the short-term relief of pain and tightness of the involved

muscles in order to facilitate participation in an active rehabilitation program and restoration of functional capacity. The evidence for TPIs when used as a sole treatment for patients with chronic low-back pain (regardless of injectate) is inconclusive and the treatment does not appear to be more effective than treatments such as laser or ultrasound. The effectiveness of trigger point injection is uncertain, in part due to the difficulty of demonstrating advantages of active medication over injection of saline. Needling alone may be responsible for some of the therapeutic response. These injections are not recommended for typical chronic low back or neck pain, nor are they recommended for radicular pain. The advantage appears to be in enabling patients to undergo remedial exercise therapy more quickly. TPIs are generally considered an adjunct rather than a primary form of treatment and should not be offered as either a primary or a sole treatment modality. Steroid injection is not generally recommended nor is Botulinum toxin. An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy.

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, NSAIDs 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.

ODG 08-10-2010 Hip Chapter: Piriformis Injections: 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.

ODG 08-17-10 Low Back Chapter: Botox Injections:

Recommended for chronic low back pain, if a favorable initial response predicts subsequent responsiveness, as an option in conjunction with a functional restoration program. Botulinum neurotoxin may be considered for low back pain (Level C). (Naumann, 2008) Paravertebral administration of botulinum toxin A in patients with chronic low back pain may relieve pain and improve function. Initial data from small trials suggest that botulinum toxin is effective, alleviating back pain in selected patients. On the basis of these promising results, additional study in larger trials is warranted. If approved, the number of trial injections should be limited to one, followed by exercise. A number of studies have evaluated the effectiveness of botulinum toxin type A in the treatment of back and neck pain, and the manufacturer is planning on pursuing FDA approval of botulinum toxin for this indication, but there is currently insufficient scientific evidence of the effectiveness of botulinum toxin in the treatment of back pain. (Foster, 2001) (Difazio, 2002) (Lang, 2004) Group health insurers do not generally cover this treatment for back pain. (Aetna, 2005) (Blue Cross Blue Shield, 2005) Some additional new data suggests that it may be effective for low back pain. (Jabbari, 2006) (Ney, 2006) In a recent double-blind, randomized, placebo-controlled study, administration of botulinum toxin A into paraspinal muscles using a novel technique produced significant pain relief in 60% of patients with chronic, refractory low back pain. A similar yield of 53% was noted in another prospective, randomized, open-label study of 75 patients, with 14 months of follow-up. In this study, an early response predicted later responsiveness, with 91% of the responders continuing to respond to repeat injections. The technique of treatment for both studies included covering the whole length of the lumbar erector spinae with one injection given at each lumbar level regardless of pain, tenderness, or trigger point location(s). The dose per injection site was 50 U (Botox), with the total dose per session not to exceed 500 U. (Jabbari, 2007) Interventional strategies such as botulinum toxin injections are not supported by convincing, consistent evidence of benefit from randomized trials. (Chou, 2008) Revisions to the prescribing information of Botox (Allergan) and Myobloc (Solstice Neurosciences) have been made: A boxed warning now highlights the possibility of experiencing potentially life-threatening distant spread of toxin effect from the injection site after local injection. Changes also have been made to the established drug names to reinforce individual potencies and prevent medication

errors. Established name changes for the botulinum toxin products are as follows: Botox (botulinum toxin type A) - onabotulinumtoxinA; Dysport (Medicis Pharm botulinum toxin type A) - abobotulinumtoxinA; Myobloc (botulinum toxin type B) - rimabotulinumtoxinB. (FDA, 2009)

PSOAS STRETCHES:

How to Stretch the Psoas Muscle | eHow.com http://www.ehow.com/how_2067121_stretch-psoas-muscle.html#ixzz0xwiZtQOP