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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: October 31, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

O/P trigger point injection enthesopathy right glutei under flouro 20552, 77002.

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

M.D., Board Certified in Orthopedic 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)

The requested service, O/P trigger point injection enthesopathy right glutei under flouro 20552, 77002, is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 10/10/11.
3. Notice of Assignment of Independent Review Organization dated 10/11/11.
4. Medical records from Bone & Joint Clinic dated 12/17/09, 3/18/10, 6/3/10, 6/17/10, 7/26/10, 8/12/10, 9/15/10, 10/14/10, 12/6/10, 3/10/11, 3/23/11, 5/17/11, 7/13/11, 7/19/11, 8/9/11, 8/26/11, 8/29/11, and 9/20/11.

5. Texas Workers' Compensation Work Status Report.
6. CT of the lumbar spine with reconstructions dated 3/18/11.
7. MRI of the lumbar spine with and without contrast enhancement dated 6/3/10.
8. Office visit report from MD dated 7/13/11 and 8/9/11.
9. Medical records from Specialty and Transplant Hospital dated 5/22/10 and 6/3/10.
10. Electrodiagnostic examination from MD dated 9/30/10.
11. Request for Pre-Authorization dated 8/2/11.
12. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with a history of back pain associated with numbness down the lower lumbar region and the right leg following a work injury on xx/xx/xx. The patient subsequently underwent a laminectomy and transforaminal fusion at L3-4, L4-5 and L5- S1 in January 2009. He was then noted to have severe stenosis with nerve root impingement, loosening screws, severe clinical radiculopathy and failed back surgery syndrome and underwent a re-do exploration of L3-4, L4-5 and L5- S1 with arthrodesis L2-3 on 5/21/10. Post-operatively, the patient continued to report leg pain but little or no back pain in 2010. Examination findings documented tenderness of the lumbosacral and iliotibial bands, limited motion, and paresthesia right calf and left foot. An EMG/NCS study performed on 9/30/10 noted findings consistent with right L5, S1 and left S2 radiculopathy. X-rays dated 12/6/10 showed four level arthrodesis to be consolidating.

A lumbar CT scan performed on 3/18/11 showed a solid anterior and posterior fusion at L2-S1, a right-sided osteophyte L4-5 with mild impression on the right L4 and L5 nerve roots and a posterior annular bulge at L1-2 with mild central spinal stenosis. Medical records from March and May 2011 noted the patient had a bit of low back pain and with numbness and achiness in the right posterior and anterior leg associated with numbness in the bottom of the feet. The patient had completed aquatic therapy and was to transition to a land based program. A follow up physician record of 7/19/11 noted the patient presented with decreased strength in the right foot dorsiflexion with continued 3 beat clonus right ankle. Mild post-operative residual radiculopathy was diagnosed. Trigger point injection enthesopathy of the right glutei was recommended.

Follow-up records of August 2011 indicated the patient had worsening low back pain, right greater than left. Tenderness was noted over the inferior aspect of the lumbar spine and the right gluteal areas. Reflex of the lower extremity Achilles and patella was diminished and motion decreased. X-rays showed translucency noted around screws which appeared to be present at all five levels. Additional medications were prescribed and trigger point injections were recommended.

A 9/20/11 the medical record noted that the patient presented with continued pain with tenderness over the L3, L4, L5 and S1 with twitch response to L4 and L5, along with tenderness over the bilateral sacroiliac joints with twitch response noted bilaterally. A request has been made for O/P trigger point injection enthesopathy right glutei under flouro 20552, 77002. The URA has denied this service, citing a lack of medical necessity.

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

Outpatient trigger point injection enthesopathy right glutei under fluoro 20552, 77002 is not medically necessary for treatment of the patient's medical condition. The Official Disability Guidelines (ODG) recommend trigger point injections for myofascial pain syndrome. Criteria for use of trigger point injections include documentation of circumscribed trigger points with evidence upon palpation of twitch response as well as referred pain, symptoms that persist for more than three months, conservative management has failed, and radiculopathy is not present. In this case there is documentation of concerns over ongoing radiculopathy, there is no documentation of a circumscribed trigger point with evidence upon palpation of a twitch response and there is documentation of conservative care. As there is ongoing radiculopathy and there is not documentation of a circumscribed trigger point with evidence upon palpation of a twitch response as well as referred pain, the requested service is not consistent with Official Disability Guidelines and therefore is not medically necessary.

Therefore, I have determined that the requested service, O/P trigger point injection enthesopathy right glutei under fluoro 20552, 77002, is not medically necessary.

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
- 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)**