

US Decisions Inc.

An Independent Review Organization
9600 Great Hills Trail Ste 150 W
Austin, TX 78759
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/03/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar intraspinal injection with trigger point injections/level /s unspecified-62311,77003, 72275, 99144, 99145, A4550 & A4649

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

M.D., Board Certified Anesthesiology/Pain Management

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds the proposed Lumbar intraspinal injection with trigger point injections/level /s unspecified-62311,77003, 72275, 99144, 99145, A4550 & A4649 is not supported as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
MRI lumbar spine without contrast 09/27/10Cns M.D. 10/25/10-06/01/12
Operative report dated 11/11/10
Operative report dated 12/02/10
EMG/NCV 01/05/11
Operative report dated 11/16/11
Operative report dated 01/19/12
Operative report dated 04/12/12
Preauthorization report dated 06/06/12
Utilization review determination dated 06/06/12
Appeal report dated 06/21/12
Utilization review determination dated 06/22/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whose date of injury is xx/xx/xx. He complains of low back pain. MRI of lumbar spine revealed broad posterior disc bulge / osteophyte complex at L5-S1 with superimposed right herniation protrusion which completely effaces the right lateral recess and encroaches on right S1 nerve root. There is minimal spinal stenosis and minimal narrowing of left lateral recess. There is minimal right and no left neural foraminal narrowing. At L4-5 there is small posterior disc bulge / osteophyte complex with small superimposed herniation protrusion with no significant spinal stenosis or foraminal narrowing at this level. Electrodiagnostic testing on 01/05/11 revealed evidence of left L4-5, L5-S1 lumbosacral radiculopathy. Records indicate the claimant has undergone multiple injections including epidural steroid injections without significant benefit. The claimant has also undergone multiple trigger point injections. A request for lumbar interspinal injection with trigger point

injections / levels unspecified 62311, 77003, 72275, 99144, 99145, A4550, and A4649 was recommended for adverse determination per preauthorization determination dated 06/06/12 noting there was no documentation of any circumscribed trigger points with appropriate twitch response and referred pain patterns.

It was further noted there was no documentation of the claimant having physical therapy, but it appears this is simply medical record oversight as opposed to true clinical deficiency. It does appear the claimant has radiculopathy by physical examination findings and nerve conduction study findings and MRI. There was no documentation of persistent pain relief obtained with previous trigger point injections. It was noted the most recent trigger point injection was less than one week ago rather than more than two months ago. There was no documentation of functional improvement specifically with trigger points. There was no documentation the claimant has ongoing home exercise program.

A reconsideration / appeal request was non-certified based on preauthorization review dated 06/21/12. It was noted that although documentation indicates the claimant has had significant relief with previous injections it does not quantify the results. It was further noted that this would be the fourth injection in less than six months and Official Disability Guidelines do not recommend more than four injections a year. It was again noted that there was no documentation of palpation with a twitch response as well as referred pain, symptoms persisting for more than three months, failure of medical management therapy such as ongoing stretching exercises, physical therapy and failure to control pain with use of NSAIDs and muscle relaxants, or absence of radiculopathy.

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

The records indicate the claimant sustained an injury to the low back on xx/xx/xx. He has evidence of radiculopathy based on clinical examination, electrodiagnostic testing and MRI findings. Records indicate that epidural steroid injections provided no significant benefit. The claimant then underwent multiple trigger point injections, reportedly with significant relief of symptoms. It appears most recent injection was performed on 04/12/12. The claimant was recommended to undergo additional injections. However, there is no documentation on physical examination of any circumscribed trigger points with twitch response and referred pain patterns. Based on the clinical data provided, the reviewer finds the proposed Lumbar intraspinal injection with trigger point injections/level /s unspecified-62311,77003, 72275, 99144, 99145, A4550 & A4649 is not supported as medically necessary per ODG criteria.

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)