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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/02/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar trigger point injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Anesthesiology and Pain Medicine

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

[X] 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 <u>each</u> health care service in dispute. It is the opinion of the reviewer that the request for lumbar trigger point injection is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. The mechanism of injury is not described. Treatment to date includes left L3-S1 medial branch radiofrequency rhizotomy on 12/02/10, bilateral L4-5 transforaminal epidural steroid injection on 05/06/11, left lumbar sympathetic block on 06/10/11, trigger point injections on 10/30/12. Note dated 12/03/14 indicates that diagnoses are lumbago, lumbar/thoracic radiculopathy, lumbar disc herniated and postlaminectomy syndrome lumbar. Office visit note dated 01/05/15 indicates that Toradol 60 mg was given and well-tolerated. Current medications are Lidoderm patch, Norco, and Lyrica. Note dated 02/03/15 indicates that the patient complains of low back pain radiating down the bilateral lower extremities rated as 5/10. On physical examination straight leg raising is positive on the left at 40 degrees. There are muscle spasms at L3 through S1 levels with tenderness.

Initial request for lumbar trigger point injection was non-certified on 12/12/14 noting that guidelines indicate that for this procedure to be considered reasonable, there should be documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain and symptoms should have persisted for more than 3 months. The submitted records do not indicate this patient has a twitch response upon palpation with circumscribed trigger points. The denial was upheld on appeal dated 12/19/14 noting that the patient has noted radiculopathy on exam which is a contraindication to doing trigger point injections as per ODG. There is also no evidence of myofascial findings such as jump sign, twitch response or referral of pain or taut bands on exam to clinically support doing this either.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on 05/08/10 due to an undisclosed mechanism of injury. The submitted records fail to provide documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain as required by the Official Disability Guidelines prior to the performance of trigger point injections. There is no comprehensive assessment of recent treatment completed or the patient's response thereto submitted for review. The Official Disability Guidelines do not support trigger point injections when radiculopathy is present. This patient presents with a diagnosis of lumbar radiculopathy. The patient's objective, functional response to prior trigger point injections is not documented. As such, it is the opinion of the reviewer that the request for lumbar trigger point injection is not recommended as medically necessary and the prior denials are upheld.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)