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Notice of Independent Review Decision

DATE OF REVIEW: December 27, 2007

AMENDED REPORT 01-04-08

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 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

Diagnostic injections of local anesthetic to cervical muscles with EMG amplification and guidance-Left sided only

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 October 1, 2007 utilization review letter from
- o October 15, 2007 letter from
- o October 12, 2007 peer-review report by, M.D.
- o October 1, 2007 peer-review report by, D.O.
- o September 26, 2007 request for utilization review form from, M.D.
- o April 4, 2007 through September 24, 2007 reports/chart notes by, M.D.
- o October 1, 2007 appeal letter by, M.D.
- o July 10, 2007 telephone conversation documentation by, M.D.
- o April 26, 2007 cervical myelogram and post myelographic CT exam report by, M.D.
- o March 27, 2006 electrodiagnostic study report by M.D.
- o September 4, 2007 electrodiagnostic study report by, M.D.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient sustained an industrial injury on xx/xx/xx. According to an October 1, 2007 peer review report, the patient is a xx year-old female who has had extensive treatment including cervical fusion, shoulder surgery, cervical radiofrequency ablation, and spinal cord stimulator. All treatments have reportedly failed. She had trigger point injections with a prior pain management physician that failed as well. The report notes that in April 2007, the physician stated that there is little to suggest myofascial pain and recommended an epidural steroid injection. This injection was denied and the physician stated that the patient had left-sided cervical spasm and he wanted to perform a diagnostic injection with local anesthetic to see if Botox is an option. The peer review physician rendered a non-certification for this request. The explanation for this decision was that the patient had had numerous aggressive interventions with no response and she was noted to be overtly depressed, which greatly reduces any positive response to injections or treatment. The reviewer pointed out that the patient has had trigger point injections before which have failed to help. The physician is looking to do these to see if Botox will be offered and Botox is not proven effective in the treatment of myofascial pain. The physician has offered a diagnosis of

torticollis, but the peer-review physician stated that there is no indication from the notes of any overt torticollis on physical exam.

An October 12, 2007 peer review report also rendered a non-certification by another reviewer. The report notes a phone consultation held with the requesting physician. The treating doctor stated that there were no true trigger points, however, he would inject some tender areas that he identified by palpation. The reason for denial was listed as the request for injections is not medically necessary based on the Official Disability Guidelines criteria for trigger point injections. The guidelines state that there must be circumscribed trigger points upon physical examination, with evidence upon palpation of the twitch response as well as referred pain.

A September 4, 2007 EMG/NCV report includes an interpretation of chronic residual cervical radiculopathy at C6-7 on the right. The denervation/reinnervation changes on needle EMG are chronic and moderate. Mild median neuropathy at the wrist (carpal tunnel syndrome) on the right was also noted.

An April 26, 2007 cervical myelogram/post myelographic CT exam report includes an impression on the cervical scout films of solid appearing anterior fusion from C5 to C7 with mild posterior bony ridging at the fused levels of C5-6 and C6-7; anterior cervical spondylosis at C4-5 exuberantly seen; significant osseous foraminal encroachment of at least moderate degree at C3-4 on the left side and of a small degree at C4-5. Cervical myelographic impression was stated as mild blunting asymmetrically of the left C4 and right C5 nerve root sleeve with contrast; mild posterior bony ridging at C5-6 and C6-7 without cord deformity identified at any level. The impression of the post myelographic CT exam of the cervical spine included solid anterior fusion from C5-C7 appearing mature with fairly good anatomical alignment without pseudarthrosis similar to findings discussed on a 2003 exam; significant left-sided foraminal encroachment of moderate degree at least again seen at C3-4 with subtle peripheral underfilling again seen of the left C4 nerve root sleeve on the CT exam correlating with myelographic findings; posterior bony ridging of 4 mm seen again at C5-6 eccentric to the left deforming a left C6 ventral outlet similar to findings discussed in 2003 without significant cord deformity or stenosis seen centrally; protrusion eccentric to the right of 2-3 mm at C4-5 without deformity of the right C5 ventral outlet with associated spondylosis and with small to moderate degree of right foraminal encroachment and minimal left foraminal encroachment similar to findings discussed in 2003 exam; 3 mm central protrusion at C2-3 unchanged to the description provided in 2003; and posterior bony ridging broad-based of 2-3 mm slightly eccentric to the right at C6-7 without nerve root deformity or stenosis unchanged to the previous findings.

The most recent report from the treating doctor, dated September 24, 2007, states that the patient rates her pain level at a 7/10. Examination findings included appearance of a little depression, guarded range of motion in all planes of the cervical spine especially rotation and flexion to the left, fairly severe muscle spasm involving the semispinalis capitis, splenius capitis, and trapezius on the left, normal shoulder range of motion, symmetric upper extremity deep tendon reflexes, unremarkable sensory testing, negative Hoffman's test, negative Spurling's test, and no long tract signs of the lower extremities. The report states that the previously denied request for an epidural injection is canceled as the patient's dystonic findings are more significant. The physician requested diagnostic injections with local anesthetics into the semispinalis capitis, splenius capitis, and trapezius muscles on the left. If good results are obtained with at least 50% pain reduction for 72 hours, a request for botulinum toxin A for the shoulder girdle and cervical dystonia will be made.

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

The Official Disability Guidelines state that Botox injections are recommended for cervical dystonia. The physician stated in his most recent report that the patient does have dystonic findings. However, the guidelines also state that cervical dystonia is a condition that is not generally related to workers' compensation injuries. The diagnosis of cervical dystonia is listed as a new problem on the most recent submitted report. The medical records fail to document that the patient has a history of cervical dystonia and failed to establish its relationship, if any, to this patient's now remote 1996 industrial injury. Given that the records fail to firmly establish the diagnosis of spasmodic torticollis/cervical dystonia and establish its relationship to the patient's industrial injury, diagnostic anesthetic injections in anticipation of possible Botox injections directed at this dystonia are not indicated. Therefore, my recommendation is to uphold the previous determinations to non-certify the request for diagnostic injections of local anesthetic to cervical muscles with EMG amplification and guidance-Left sided only.

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

____ 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

____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

Official Disability Guidelines (2007):

Botulinum toxin (injection):

Recommended for cervical dystonia, but not recommended for mechanical neck disorders, including whiplash. See more details below.

Not recommended for the following: headache; fibromyositis; chronic neck pain; myofascial pain syndrome; & trigger point injections. Several recent studies have found no statistical support for the use of Botulinum toxin A (BTX-A) for the treatment of cervical or upper back pain, including the following:

- Myofascial analgesic pain relief as compared to saline. (Qerama, 2006)

- Use as a specific treatment for myofascial cervical pain as compared to saline. (Ojala, 2006) (Ferrante, 2005) (W heeler, 1998)

- Injection in myofascial trigger points as compared to dry needling or local anesthetic injections. (Kamanli, 2005) (Graboski, 2005).

Recent systematic reviews have stated that current evidence does not support the use of BTX-A trigger point injections for myofascial pain. (Ho, 2006) Or for mechanical neck disease (as compared to saline). (Peloso-Cochrane, 2006) There is one recent study that has found statistical improvement with the use of BTX-A compared to saline. Study patients had at least 10 trigger points and no patient in the study was taking an opioid. (Gobel, 2006) Botulinum toxin A (e.g., Botox) remains under study for treatment of chronic whiplash associated disorders and no statistical difference has been found when compared to treatment with placebo at this time. (Freund, 2000) (Aetna, 2005) (Blue Cross Blue Shield, 2005) (Juan, 2004)

Recommended: cervical dystonia, a condition that is not generally related to workers' compensation injuries (also known as spasmodic torticollis), and is characterized as a movement disorder of the nuchal muscles, characterized by tremor or by tonic posturing of the head in a rotated, twisted, or abnormally flexed or extended position or some combination of these positions. In recent years, botulinum toxin type A has become first line therapy for cervical dystonia. When treated with BTX-B, high antigenicity limits long-term efficacy. Botulinum toxin A injections provide more objective and subjective benefit than trihexyphenidyl or other anticholinergic drugs to patients with cervical dystonia. (Costa-Cochrane, 2005) (Costa2-Cochrane, 2005) (Costa3-Cochrane, 2005) (Jankovic, 2006) (Lew, 1997) (Trosch, 2001) (Balash, 2004) (Sycha, 2004)

Official Disability Guidelines (2007):

Trigger point injections:

Not recommended in the absence of myofascial pain syndrome. See the Pain Chapter for Criteria for the use of Trigger point injections. 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. The only indication with some positive data is myofascial pain; may be appropriate when myofascial trigger points are present on examination. Trigger point injections are not recommended when there are radicular signs, but they may be used for cervicalgia. (Bigos, 1999) (Colorado, 2001) (Nelemans-Cochrane, 2000) (BlueCross BlueShield, 2004)

