

## Notice of Independent Review Decision

### **DATE OF REVIEW:**

11/24/2009

### **IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Trigger point injections, electrical stimulation, massage, para-vertebral injections (20550, 97032, 97124, 64470, and 64472) with 12 visits over the next 3 months.

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

Doctor of Osteopathy, Board Certified Anesthesiologist, Specializing in Pain Management

### **REVIEW OUTCOME**

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

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**Trigger point injections, electrical stimulation, massage, para-vertebral injections (20550, 97032, 97124, 64470, and 64472) with twelve visits over the next three months is not medically necessary.**

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- TDI/DIVISION OF WORKERS' COMPENSATION referral forms
- 11/16/09 Fax cover sheet with note
- 11/13/09 Notice To MCMC, LLC Of Case Assignment, DWC
- 11/13/09 Notice of Assignment of Independent Review Organization, DWC
- 11/11/09 Confirmation of Receipt of a Request For a Review, DWC
- 10/05/09 Request For a Review By An Independent Review Organization
- 10/02/09 Notice of Reconsideration letter,
- 10/02/09 (date referred to peer) Peer Review, M.D., Services
- 09/29/09 Peer Review, DO, Services
- 09/28/09 Notice of Denial of Pre-Authorization letter
- 09/25/09 Notice of Denial of Pre-Authorization letter
- 09/16/09 Summary Report, M.D.
- 09/11/09 letter from claimant
- 08/04/09 to 09/04/09 office notes, M.D.

- 09/25 Utilization Management Referral
- Note: Carrier did not supply ODG Guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured individual is a female with date of injury xx/xx. The injured individual had right shoulder surgery in xx/xx. The attending provider (AP) gives her the diagnosis of cervical/thoracic spondylosis without an MRI or x-ray and Reflex Sympathetic Dystrophy (RSD) with no RSD findings documented. He has done months of weekly injections combined trigger point injections (TPIs), acupuncture, non-fluoroscopically guided cervical facet injections along with e-stimulation and manual therapy/osteopathic manipulative therapy (OMT). Her pain score from 08/2009 to 09/2009 went from 8 to 5/10; her overall improvement rated from 30% to 50%. The injured individual indicated she has been treated by him this way for five months but those prior notes are not provided.

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

The injured individual has had five months of this combination treatment per her letter. She is at best 50% better yet her pain score only went from 8/10 to 5/10 and she remains on Suboxone and trazodone. The AP is doing TPIs, acupuncture, cervical facet injections at three joints without fluoroscopy, and e-stimulation/manual therapy/OMT once a week or so based on the notes provided. Not only is this an excessive combination of injections and passive therapy but the frequency is also excessive. Official Disability Guideline does not support TPIs more than once every six weeks and facet injections only once as a diagnostic procedure. Also, facet (paravertebral blocks) should be done with fluoroscopic guidance. Finally, there is no cervical MRI or x-ray to verify pathology nor are there physical exam (PE) findings of sympathetically mediated pain to support his diagnosis of "much maligned RSD". Due to the excessive nature and frequency of this treatment and lack of significant benefit, further treatment is denied.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:****ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Official Disability Guideline (ODG) for TPI: Criteria for the use of TPIs (Trigger point injections): TPIs with a local anesthetic 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) No 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) TPIs 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 a lack of appropriate 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 for estim: Not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. (Moore, 1997) (Gaines, 2004) The scientific evidence related to electromyography (EMG)-triggered electrical stimulation therapy continues to evolve, and this therapy appears to be useful in a supervised physical therapy setting to rehabilitate atrophied upper extremity muscles following stroke and as part of a comprehensive PT program. Neuromuscular Electrical Stimulation Devices (NMES), NMES, through multiple channels, attempts to stimulate motor nerves and alternately causes contraction and relaxation of muscles, unlike a TENS device which is intended to alter the perception of pain. NMES devices are used to prevent or retard disuse atrophy, relax muscle spasm, increase blood circulation, maintain or increase range-of-motion, and re-educate muscles. Functional neuromuscular stimulation (also called electrical neuromuscular stimulation and EMG-triggered neuromuscular stimulation) attempts to replace stimuli from destroyed nerve pathways with computer-controlled sequential electrical stimulation of muscles to enable spinal-cord-injured or stroke patients to function independently, or at least maintain healthy muscle tone and strength. Also used to stimulate quadriceps muscles following major knee surgeries to maintain and enhance strength during rehabilitation. (BlueCross BlueShield, 2005) (Aetna, 2005)

ODG for massage and OMT 99124: Recommended for chronic pain if caused by musculoskeletal conditions, and manipulation is specifically recommended as an option in the Low Back Chapter and the Neck Chapter. (For more information and references, see those chapters.) Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. See also specific body-part chapters below:

Low back: Recommended as an option. Therapeutic care – Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks.

Elective/maintenance care – Not medically necessary. Recurrences/flare-ups – Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months.

Neck and upper back: Recommended as an option. See chapter for specific recommendations according to condition.

Head: Recommended for the prophylactic treatment of headaches (not a chronic pain treatment).

Hip: Recommended as an option. See chapter for specific recommendations according to condition.

Elbow: Recommended only on a short-term limited basis. See chapter for specific recommendations according to condition.

Shoulder: Recommended as an option. See chapter for specific recommendations according to condition.

Ankle & Foot: Not recommended.

Carpal tunnel syndrome: Not recommended.

Forearm, Wrist, & Hand: Not recommended.

Knee: Not recommended.

ODG for paravertebral injections: While not recommended, criteria for use of therapeutic intra-articular and medial branch blocks, if used anyway:

Clinical presentation should be consistent with facet joint pain, signs & symptoms.

1. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.
2. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive).
3. When performing therapeutic blocks, no more than 2 levels may be blocked at any one time.
4. If prolonged evidence of effectiveness is obtained after at least one therapeutic block, there should be consideration of performing a radiofrequency neurotomy.
5. There should be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy.
6. No more than one therapeutic intra-articular block is recommended.