CLAIMS EVAL

*Utilization Review and Peer Review Services*

Notice of Independent Review Decision-WC

**CLAIMS EVAL REVIEWER REPORT - WC**

**DATE OF REVIEW: 12-30-09**

**IRO CASE #:**

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

Trapezial trigger point injections x 4

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

American Board of Anesthesiology and Pain Medicine

**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 or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- MD., office visits on 4-1-09, 9-3-09, and 11-18-09.
- 4-8-09, Dr. reported a medical conference.
- 11-30-09 DO., performed a Utilization Review.
- 12-2-09 MD., appeal letter.
- 12-11-09 MD., performed a Utilization Review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

On 4-1-09, the claimant was evaluated by MD., who reports the claimant has done well with trigger point injections and occipital nerve blocks as needed. She has not had trapezial trigger point injections in the last two years. She has been having a lot of spasms, especially in the trapezial and interscapular areas. She takes Robaxin, Trazadone, Feldene and Topamax. She gets Hydrocodone from her family physician who performed reconstruction breast surgery. She has had an abdominal would infection with staph and pseudomonas, which has left significant scarring and she is going to have this reconstructed. On exam, the claimant was tender to the posterior cervical and upper trapezial areas. The claimant had trigger points with a positive twitch response. The evaluator provided the claimant with Medrol Dosepak for her acute pain. She was provided with a refill for Trazadone, Prozac, Topamax, Robaxin and Feldene. The evaluator requested trigger point injections x 4.

On 4-8-09, Dr. reported he had a medical conference and discussed the need for trapezial trigger point injections.

Followup with Dr. dated 9-3-09 notes the claimant had trigger point injections and occipital nerve blocks in the past, which have helped with some of her pain. Her current medications include Robaxin, Trazadone, Feldene and Topamax. She no longer takes Hydrocodone. On exam, the claimant has tenderness to palpation in the posterior cervical and upper trapezial areas. There are trigger points palpable with a positive twitch response. Motor strength is 5/5, DTR are 2+. She has hypoesthesia to pin in the right C6 distribution. The evaluator provided the claimant with a Medrol Dosepak for her acute pain. The evaluator requested routine lab work.

Followup with Dr. MD., on 11-18-09 notes the claimant is being followed for chronic neck pain. The claimant is status post C5-C7 ACDF, which is solid. He has some retrolisthesis in extension at C4-C5 on her last CT scan of 8-1-07. The evaluator reported the claimant had trigger point injections and occipital nerve blocks in the past, which helped. Her current medications include Robaxin, Trazadone, Feldene and Topamax. She had been relatively stable until approximately two months ago. She had exacerbation and was given Medrol Dosepak, which helped temporarily. On exam, the claimant is tender in the trapezial area, right worse than the left. DTR are 2+ and symmetric. Motor strength is 5/5 in all major muscle groups. There is hypesthesia in

the right thumb and index finger. The evaluator recommended repeat cervical spine series with flexion and extension. The evaluator changed her Prozac to Cymbalta. Her Feldene and Trazadone were filled. The claimant will increase Topamax to 50-100 mg bid. The evaluator requested trapezial trigger point injections x 3.

On 11-30-09 DO., performed a Utilization Review. It was his opinion that there had not been an up to date followup report as the latest follow up provided was dated 4-1-09. The evaluator reported that there was no evidence that the claimant had been or whether there is still an ongoing conservative treatment, which should include home exercise program and stretching. The operative reports of the previous injections were not provided. Therefore, the evaluator reported that the request was deemed not substantiated at this point in time.

An appeal letter provided by Dr. dated 12-2-09 notes the claimant is being followed for residual neck pain. He noted the claimant has had trigger point injections in the past, her last ones were in 2006. The claimant was approved for repeat trigger point injections in April 2009, but these were not performed. She was relatively stable until approximately two months ago and has had an exacerbation. She was given Medrol Dosepak, which helped temporarily. On exam, the claimant was found to have well-circumscribed trigger points with a positive twitch response. The evaluator noted that this was noted in his 11-18-09 visit. The evaluator reported the claimant has no evidence off current radiculopathy. The evaluator reported the claimant did receive significant improvement with her trigger point injections in 2006 and indeed was relatively stable until approximately September 2009 as stated in the history.

On 12-11-09, MD., performed a Utilization Review. The reviewer reported that the clinic note on 11-18-09 was not submitted. Therefore, the evaluator reported that based on insufficient clinical documentation, the medical necessity cannot be established for the requested appeal trapezial trigger point injections x 4.

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

MEDICAL RECORDS REFLECT THIS CLAIMANT HAS ONGOING NECK PAIN. ON EXAM, THE CLAIMANT HAS WELL CIRCUMSCRIBED TRIGGER POINTS WITH A POSITIVE TWITCH RESPONSE. THE CLAIMANT HAS RESPONDED PREVIOUSLY TO TRIGGER POINT INJECTIONS. ACCORDING TO ODG, TRIGGER POINT INJECTIONS ARE RECOMMENDED FOR MYOFASCIAL PAIN SYNDROME. BASED ON DOCUMENTATION PROVIDED, THE CLAIMANT DOES MEET ODG CRITERIA FOR THE REQUESTED TRIGGER POINT INJECTIONS. THEREFORE, THE REQUEST FOR TRAPEZIAL TRIGGER POINT INJECTIONS X 4 IS REASONABLE AND MEDICALLY INDICATED.

**ODG-TWC, last update 12-8-09 Pain – trigger point injections**: Recommended for myofascial pain syndrome as indicated below, with limited lasting value. The advantage appears to be in enabling patients to undergo remedial exercise therapy more quickly. The primary goal of trigger point therapy is the short-term relief of pain and tightness of the involved muscles in order to facilitate participation in an active rehabilitation program

and restoration of functional capacity. TPIs are generally considered an adjunct rather than a primary form of treatment and should not be offered as either a primary or a sole treatment modality. (Scott, 2005) See Myofacial pain. A recent systematic review came to the conclusion that the efficacy of TPIs was no more certain than it was a decade ago, and that there continued to be no clear cut evidence of either benefit or ineffectiveness. There is no evidence-based or consensus research to suggest an optimal technique. The mechanism of inactivation of the trigger point remains unknown. Many consider dry needling as effective as a TPI. It has been suggested that the main effect is placebo. (Cummings, 2001) There are no studies that compare “stretching” treatment alone or “no treatment” to TPIs. Most current studies have evaluated the use of a TPI as a stand-alone treatment. (Scott, 2008) (Staal, 2008)

Indications: The main indication is to inactivate the trigger point in order to reduce pain and restore function. This may enable physical therapy. The injection is also used as a diagnostic tool. (Scott, 2008) Whiplash and chronic head, neck, shoulder and back pain: The evidence for TPIs when used as a sole treatment for patients with whiplash syndrome or chronic head, neck, shoulder or back pain (regardless of injectate) is inconclusive and the treatment does not appear to be more effective than treatments such as laser or ultrasound. These injections are not recommended for typical chronic low back or neck pain, nor are they recommended for radicular pain. Fibromyalgia: There is no evidence to support trigger point injections for this condition using randomized controlled trials. Uncontrolled trials suggest that dry needling or soft-tissue injections with lidocaine are equally effective. (Goldenberg, 2004) Cervicogenic headaches: The effectiveness is unknown. (Scott, 2005) Osteoarthritis: There is one randomized controlled trial that indicates that the addition of TPIs to intra-articular injections improves pain and function over and above the latter injection alone. (Yentur, 2003)

Needling procedures: The standard definition of TPIs (also called direct wet needling) involves injecting fluid directly into the trigger point. (Cummings, 2001) Other needling techniques include injection of fluid over the trigger point into the skin or subcutaneous tissue, direct dry needling, or indirect dry needling (the needle is placed superficially or deep into classic acupuncture points or over a tender spot, but not into the trigger point). See Acupuncture.

Injection fluids: The injection of a local anesthetic can reduce the pain of a trigger point. TPIs with an anesthetic such as bupivacaine are recommended for non-resolving trigger points. In addition, the addition of a local anesthetic can reduce the pain of injection. The addition of a corticosteroid is not generally recommended and there is moderate evidence that TPIs with corticosteroids do not produce significantly different results from placebo injections using short-term self reports. Current evidence does not support the use of Botulinum toxin in trigger point injections for myofascial pain. (Ho, 2007) (Peloso, 2007)

Adverse effects: The following have been published in case reports: cervical epidural abscess; accidental intrathecal injection; muscle atrophy at the injection site; pneumothorax; development of asystole. There is also a concern that when used as a primary therapy patients may become dependent on this treatment, diverting from the

underlying factors causing and maintaining pain. (Borg-Stein, 2002) Vasovagal responses are the most frequent complication. Other complications include bleeding, cuts or tears to the muscle, injury to nerve fibers, damage to blood vessels, infection, and allergic reactions (including anaphylaxis). Contraindications: Acute cases of muscle trauma; Allergies to anesthetic agents; Bleeding disorders; Local or systemic infection; Anticoagulant use.

Trigger point definitions: A trigger point is a hyperirritable foci located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Pain is generally reported on compression, with common evidence of characteristic referred pain. This may or may not be accompanied by an autonomic response. Trigger points may be present in up to 33-50% of the adult population. There is currently no satisfactory objective, biochemical, electromyographic, or diagnostic imaging test to diagnosis trigger points. (Scott, 2008) Active trigger point: Continuous pain is generated in the zone of reference with or without palpitation. Latent trigger point: No evidence of spontaneous pain but evidence of restricted movement and muscle weakness. Primary trigger point: develop independently of other trigger points. Satellite trigger points: result from stress and muscle spasm caused by neighboring trigger points. (Scott, 2005) Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. A cluster of symptoms is noted including pain, autonomic phenomena and muscle dysfunction. Examples of primary myofascial pain syndrome include tennis elbow, frozen shoulder and chronic tension type headache. Secondary myofascial pain is found in the presence of conditions such as whiplash, TMJ dysfunction, and osteoarthritis. Psychosocial factors may contribute to muscle tension and an increase in pain, in particular, anxiety. (Esenyel, 2000) (Nifosi, 2007) (Altindag, 2008) (Graff-Radford, 2004) (BlueCross BlueShield, 2004) (Nelemans-Cochrane, 2002) See also the Low Back Chapter.

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.

**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)**