



MedHealth Review, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: 8/1/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of trigger point and bursa injections, left shoulder, under fluoroscopy and IV sedation. (20553, 20610 and 77002)

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of trigger point injection to the left shoulder, under fluoroscopy and IV sedation.

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a bursa injection to the left shoulder.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: and, DO.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 4/22/11 letter by, 7/1/11 denial letter, 7/5/11 reconsideration letter by, 7/7/11 denial letter, 5/19/11 review by MRloA, 7/7/11 review by MRloA, 10/22/09 to 5/11/11 office notes by Dr. 5/4/11 operative report, 11/15/06 cervical CT report, 8/2/05 CT myelogram report of the C-spine and 8/2/05 cervical spine myelogram.

Dr.: 6/6/11 office note by Dr.. (all other records were duplicative)

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, this worker was injured in a work related accident on xx/xx/xx. Records indicate that a block of concrete fell approximately five to six feet striking him on the neck and shoulder area. He reportedly had “numerous surgical interventions” including cervical fusions at the C2-3, C3-4, and C5-6 levels and arthroscopic surgery on the left shoulder.

On October 22, 2009, the injured worker was evaluated by a pain management specialist, D.O. Dr. described chronic neck and right shoulder pain. He diagnosed a post laminectomy pain syndrome, neuropathic pain syndrome, chronic myofascial pain syndrome, and moderate depression and anxiety. Dr. recommended treatment with physical therapy and modalities, further titration of neuropathic and antidepressant support, and interventional pain care with cervical epidural block with catheter approach with lysis of epidural adhesions, and injection of anesthetic and corticosteroids.

On April 7, 2011, a note from Dr. indicated that the injured worker had “near complete resolution of neck, shoulder, and arm complaints following a series of epidural blocks.” He noted that the injured worker was taking Cymbalta 60 mg in the morning and Klonopin at bedtime as well as two Norco tablets per day. Dr. stated that “the remainder of his pain is about his posterior left shoulder.” Clinical findings were said to be consistent with subacromial and posterior deltoid bursitis with pain with abduction, pinpoint pressure, and good range of motion. On that date, Dr. recommended a left steroid bursal injection and continued medication management, exercise therapy, and rehabilitation efforts.

On May 4, 2011, Dr. performed a left subacromial bursal injection with local anesthetic and steroid and two posterior trigger point injections. On May 11, seven days following the injection, Dr. noted that the injured worker had obtained “ninety percent improvement in left shoulder and arm complaints.” He stated that the injured worker had only “a little twinge” in the left shoulder. The injured worker was continuing to complain of neck pain. Dr. recommended a second

injection, an increase in Cymbalta, continuation of Klonopin and Norco 10 mg t.i.d. and continued exercise, rehab, and behavioral modalities. Dr. stated that he “will arrange a second trigger point injection with shoulder bursal injection in the near future.”

On June 6, 2011, Dr. stated that the pain relief originally received was waning. On June 6, approximately four weeks following the original injection, the injured worker had only fifty percent improvement. He showed moderate trigger point tenderness with decreased range of motion of the shoulder joint and trigger point tenderness over the trapezius and posterior deltoid region. There was mild tenderness over the acromioclavicular joint which was aggravated with internal and external rotation of the shoulder. Dr. reported that the injured worker’s affect had stabilized. A request for repeat trigger point and bursal injections was denied according to letters dated May 19, 2011, July 1, 2011, and July 7, 2011.

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

Diagnoses of post laminectomy pain syndrome, neuropathic pain syndrome, chronic myofascial pain syndrome, and moderate depression and anxiety were made. The injured worker apparently had cervical epidural steroid injections at some point in time and a left subacromial bursal injection and trigger point injections performed on May 4, 2011. One week later, Dr. documented “ninety percent improvement” in left shoulder and arm complaints. Four weeks following the injections, Dr. stated that the pain relief original received was waning and at that four-week period was only approximately fifty percent improved. Trigger point tenderness and decreased range of motion of the shoulder joint were described. The trigger points were not further described.

According to ODG Treatment Guidelines under the shoulder section entitled “impingement tests” the Guides describe three degrees of severity of rotator cuff disease: “Bursitis, Partial thickness rotator cuff tears, and Full thickness cuff tears.” Apparently, this injured worker was in the “bursitis” phase of rotator cuff disease. Steroid injections are recommended for rotator cuff disease and “may be superior to physical therapy intervention for short term results.” Imaging guided subacromial steroid injections are recommended to ensure that the steroid is placed in the subacromial bursa and not in the peri bursal soft tissue. Up to three injections are recommended and this injured worker has already received one injection. A second bursal injection would be appropriate according to ODG Guidelines.

ODG Guidelines state that trigger point injections can be performed in the presence of a myofascial pain syndrome. The trigger points are described as “circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain.” In order for trigger point injections to meet ODG Treatment Guidelines, symptoms must have persisted for more than three

months and medical management should have failed to adequately control the pain. There should be no evidence of radiculopathy. Trigger point injections should be repeated only if there is documentation of greater than fifty percent of pain relief with reduced medication use obtained for six weeks following injection and if there is evidence of functional improvement.

The Guides further state that it should be remembered that trigger point injections are used only as an adjunct and not as a primary treatment for myofascial pain trigger points. In this medical record, there is evidence of “ninety percent” relief at one week following the injections, but apparently, the relief obtained rapidly decreased to the fifty percent point at four weeks following injection. There is no description of improvement of fifty percent at six weeks and no description of reduced medication use or evidence of functional improvement.

There is no indication in this medical record of why intravenous sedation would be necessary for shoulder and trigger point injections. ODG Guidelines do not provide for use of intravenous sedation for those injections and the record gives no explanation for why such sedation would be required for trigger point and bursal injections in this injured worker.

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)**