

SENT VIA EMAIL OR FAX ON
Nov/28/2011

P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 405-0878
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Nov/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Trigger Point Injections for the Cervical Spine and Shoulder

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines

Cover sheet and working documents
Utilization review determination dated 11/04/11, 10/25/11
Peer review report dated 10/24/11, 11/03/11
Operative report dated 09/07/11, 02/08/11
Follow up note dated 10/25/11, 10/13/11, 09/14/11, 01/24/11, 07/26/11
MRI cervical spine dated 06/25/10
MRI brain dated 05/19/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was departing a school bus when she slipped and fell, hitting her head. MRI of the cervical spine dated 06/25/10 revealed cervical spondylosis and scattered discogenic changes without discrete impingement. The patient underwent left greater occipital nerve block on 02/08/11.

Follow up note dated 07/26/11 indicates that the patient got excellent relief of her cervicogenic headache and post traumatic occipital neuralgia with the block. The patient underwent left greater occipital nerve block and myofascial trigger point injections of the cervical spine on 09/07/11. Follow up note dated 09/14/11 notes significant reduction of neck pain, improved range of motion, decreased burning in her head and neck following the injections. The patient underwent trigger point injections on 10/13/11. Follow up note dated 10/25/11 indicates that the patient reports near complete resolution of her neck and upper back pain. The patient still had some jump signs and some moderate tenderness over these trigger areas.

Initial request for trigger point injections was non-certified on 10/25/11 due to lack of documentation of myofascial pain syndrome. The patient has had improvement, but has not sustained functional improvement from prior injections. The denial was upheld on appeal dated 11/04/11 noting that the patient underwent trigger point injections approximately 2 weeks prior. There has been insufficient passage of time to verify a therapeutic response or support repeat injections. ODG requires over six weeks of benefit from TPIs to warrant repeating them. The last note indicates there are findings at the left rhomboid, but the AP never documents which muscle group(s) he wants to inject or how many.

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

Based on the clinical information provided, the request for trigger point injections for the cervical spine and shoulder is not recommended as medically necessary, and the two previous denials are upheld. The patient has undergone previous trigger point injections; however, the submitted records fail to document greater than 50% pain relief with reduced medication use for six weeks after the injection with documented evidence of functional improvement as required by the Official Disability Guidelines. There is no current, detailed physical examination submitted for review documenting circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. The submitted records fail to establish that the patient has undergone medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants which have failed to control pain. Given the current clinical data, the requested trigger point injections are not indicated as medically necessary.

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

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)