

ALLMED REVIEW SERVICES INC

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Notice of Independent Review Decision for Health

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DATE OF REVIEW: 7/11/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Trigger Point Cervical 20550, 20551, 20553 from 5-28-12 through 7-28-12

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

Board Certified in Physical Medicine and Rehabilitation.

REVIEW OUTCOME:

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

- | | |
|--|----------------------------------|
| Upheld | (Agree) |
| <input type="radio"/> Overturned | (Disagree) |
| <input type="radio"/> 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:

Records Review includes:

- I. 5/9/12 Adverse determination notice
2. 6/4/12 Adverse determination notice
3. MD notes from 5/1/12 and 12/9/11
4. 12/9/11 radiograph report
5. 10/17/11 MRI for the cervical and lumbar region
6. 5/1/12 DWC-73 form
7. and Attorney Letter
8. TAC, Title 28, Subchapter A Provisions
9. ODG criteria for Trigger Point injection for Cervical region.

PATIENT CLINICAL HISTORY [SUMMARY]:

See attached report

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

See attached report

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
- NIOSH/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)

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IROREVIEW

ADJUSTER: r

CLAIMANT:

DOI:

xxx-xx-7216

CLAIM NO:

7

SSN:

IRONO:

DATE OF REVIEW:

INTRODUCTION:

Records Review includes:

1. 5/9/12 Adverse determination notice
2. 6/4/12 Adverse determination notice
3. MD notes from 511112 and 12/9/11
4. 12/9/11 radiograph report
5. 10/17111 MRI for the cervical and lumbar region
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7. Attorney Letter
8. TAC, Title 28, Subchapter A Provisions
9. ODG criteria for Trigger Point injection for Cervical region.

BRIEF HISTORY:

I reviewed medical records regarding, claim. I have been asked to address issues related to cervical trigger point injections. Reconsideration request received May 24, 2012. This had been previously reviewed and uncertified. Medical records submitted include prior determination June 4, 2012 Services Corporation. There are also notes and evaluations from Institute, dated May I, 2012 by Dr. in addition to December 9, 2011 note of Dr. from Institute. In addition, there is a radiology report December 9, 2011 from Institute read by Dr. Medical records also contained a cervical MRI report dated October 17, 2011 from that is

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MR! dated October 17, 2011. The referring clinician is chiropractor, Dr. .

Clinical History:

Claimant is a woman, who reports motor vehicle accident xx/xx/xx when she was delivering some mail. She reports working as an administrative assistant and was involved in a rear-end motor vehicle collision. There was no first report of injury available for review. There are no emergency room notes available for review. Dr. evaluated Ms. on December 9, 2011. This was initial visit. The incident had occurred nearly three months before. She was complaining of cervical and lumbar spine pain since that time. Her low back pain was worse from the neck pain. She indicated she had been fired from her job and she had received some chiropractic care in physical therapy, which helped. The chiropractic notes and physical therapy notes were not included for review. She reported that she felt worse with standing, walking and physical activity. Dr. notes that she had a lumbar MR! performed, which showed a 2 mm to 3 mm right paracentral protrusion herniation at L4- L5 with a similar finding at L5-S1 on the right side. In addition, cervical spine showed a 2 mm right paracentral disc herniation at C3-C4 and C4-C5, which were performed on October 17, 2011. Reviewing medical records, there is a cervical MR! report dated October 17, 2011 read by radiologist, Dr.. Dr. notes that at C3-C4 and C4-C5, there was a 2 mm right paracentral disc protrusion/herniation, but was without bony compression or fracture or contusion. This did not contact the anterior spinal cord surface. There were widely patent anterior, posterior, and transverse cervical spinal canal diameters. There was some cervical lordosis straightening suggesting muscle pain and spasm.

Dr. notes that Ms. had no known allergies and the past medical history was significant for anxiety, depression, and hypothyroidism. She had no past surgical history except for some clavicle surgery as a teenager. Medications included Synthroid, Wellbutrin, and Licorice Plus.

Social History: She is married. Had children. Does not smoke, does not drink alcohol. Graduated high school.

Physical Examination: Notes that she is 5 feet tall, weighed 125 pounds. She appeared to be in no acute distress. Strength was 5/5 in both upper and lower extremities. Range of motion was intact in the upper and lower extremities. There was some restricted range of motion with back flexion with some diffuse paraspinal tenderness throughout the lumbar spine. She had positive straight leg raising at 60 degrees. There are no other abnormalities noted in the cervical spine.

The overall impression by Dr. was that she had cervical strain with some underlying cervical disc protrusion with some initial radicular pain that had essentially resolved itself with the physical therapy to date. He recommended that she continue physical therapy for both the neck and low back. He noted that her neck pain was a lot better, but her low back pain seemed to be a primary source of complaint. She had difficulty tolerating long periods of standing or walking. A right sided L4-L5 transforaminal epidural steroid injection was recommended. In addition, he recommended a trial of Skelaxin. She had taken Flexeril in the past, but could not tolerate it. In addition, he recommended a course of Lodine as an anti-inflammatory. She was to continue to work with chiropractic Dr. for return to work. Dr. notes that she had been fired from her job and needed to focus on recovery.

Followup was to be scheduled after her injections. Dr. noted that she had been performing physical therapy for two months, but still had persistent pain in the lumbar spine.

Medical records contain a followup visit with Dr. dated May 1, 2012 or six months later. At this time, he notes he has not seen her since December 2011 and had been instructed to do home exercises as instructed by Dr.. She had also been taking medication including muscle relaxant Robaxin and anti-inflammatory Lodine as well as Norco. She had a primary care physician, Dr.. She was still not working. She was taking care of her children. Her primary complaint when she was seen on May 1, 2012 was that she was having right-sided neck and shoulder girdle pain. She had also been complaining of some right sided mid rib cage, when she would work out. It was not necessarily painful. Her radicular right leg pain had essentially resolved and it was mainly just low back ache. On physical examination, she was noted to be in no acute distress. Her vital signs were stable. Blood pressure 120/76, pulse 84, height 5 feet 2 inches, weight 125 pounds. Upper and lower extremity strength was 5/5. Gait was independent. Straight leg raising was negative. She had some myofascial tenderness in the right cervical paraspinal down to the trapezial area levator scapulae. Dr. Lankford believed that she had some residual myofascial dysfunction with trigger points on the right side. He recommended continued conservative care, physical therapy, home exercise, and oral medication, and trigger point injections, which would be used in conjunction with the home exercise and active rehab. A followup was to be scheduled after those trigger point injections.

I have been asked to address issues related to trigger point injections. Previously, the trigger point injections have been denied under utilization review. In this case, Ms. Black has been seen only twice by Dr. with a six-month period of time intervening. When he had seen her on December 9, 2011, her low back pain was worse than the neck pain. At that point, he felt that her cervical strain problem had essentially resolved itself with the physical therapy. A trial of Skelaxin was to take place as well as Lodine. She had subsequently been prescribed Robaxin. She was not working and there were no specific rehab or chiropractic notes available for review. The trigger points are small,

definite abnormally sensitive areas of muscles, ligaments, joint capsules, tendons, and tissues that have specific in typical area of referred pain. The trigger point is called this because its stimulation reproduces the pain. Any kind of local injury to myofascial structures can induce trigger points and other causes of trigger points can include inflammation, myositis, bursitis, arthritis, tendinitis, chronic infection, connective tissue disease, stress as well as a number of other causes. Injections are generally performed along with physical therapy so that patient take advantage of pain relief from the injection and increase their activity tolerance. In this case; however, there are no physical therapy or chiropractic notes available for review. There is no information that suggests that her cervical pain complaints are specifically difficult to manage.

Reviewing ODG guidelines, there are a number of criteria for the use of trigger point injections. ODG guidelines recommend trigger point injections for myofascial pain syndrome, but note that they have limited lasting value. The advantage appears to be enabling patients to undergo remedial exercise therapy more quickly. The primary goal of trigger point therapy is with short term relief of pain and tightness of the involved muscles in order to facilitate participation in an active rehab program and restoration of functional capacity. Trigger point injections are therefore considered an adjunct rather than a primary form of treatment and should not be offered as either primary self-treatment modality.

In this particular case, however, Dr. has recommended continued conservative care, physical therapy, home exercise, and oral medication. The specific dose of medication is not listed or medication regimen. Similarly, the specific stretching as part of home exercises, physical therapy, chiropractic visits are not included for review. In addition, Ms. had been seen in the emergency room and prescribed Norco, which is a narcotic medication. It is unclear why she has required opiate/narcotic medications from the notes from Dr.. Similarly, her primary care physician as listed as Dr. in Forney, but his notes are not available for review.

ODG guidelines note that trigger point injections of 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. (Comment: Medical notes from Dr., however, do not specifically identify circumscribed trigger points except in a very general way).
2. Symptoms have persisted for more than three months.
3. Medical management therapy such as ongoing stretching exercise, physical therapy, nonsteroidal anti-inflammatory medications, and muscle relaxants have failed to control pain.
4. Radiculopathy is not present by exam, imaging, or neuro-testing.
5. No more than three-four injections per session.

6. No repeat injections unless greater than 50% pain relief with reduced medication use is obtained for six weeks after injection and there is documented evidence of functional improvement.
7. Frequency should not be at an interval less than two months.
8. Trigger point injections with any substance, saline or glucose other than local anesthetic with or without steroid use 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 two to three injections, the treatment plan should be reexamined, as this may indicate a lack of appropriate diagnosis, lack of success with this procedure, or 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.

The specific course of followup has not been identified by Dr.. As noted, he has only evaluated Ms. twice with a six-month interval.

QUESTION:

1. Please address medical necessity of Trigger Point Cervical for dates of service 5/28/12 through 7/28/12 with CPT code 20550, 20551, and 20553. Please base opinion on ODG criteria supplied.

Answer:

Given the information presented, Trigger point (injections) Cervical with CPT code 20550, 20551, and 20553 could not be recommended at this time based on the information reviewed.

The criteria for the use of trigger point injections as proposed by ODG guidelines have not been met. The prior notes from December 2011 suggested that the cervical pain complaints had nearly resolved. Six months later on May 1, 2012, however, she is complaining of cervical pain with right-sided neck and shoulder girdle pain. She is taking care of her children and some of these pain complaints may be completely unrelated to a prior motor vehicle accident of September 14, 2011 and still related to a number of other factors including stress, deconditioning, or another medical problem. As noted, the neck symptomatology is not well described in the latest note May 1, 2012.

The proposed treatment plan using trigger point injections is not specifically noted in followup with Dr. Specific short and long-term goals including return to work goals are not noted or indicated. It is unclear whether there are certain emotional factors or behavioral factors such as her remaining out of work or her involvement with her kids, etc are playing a role in her chronic pain complaints. The physical examination,

however, shows that she is in no acute distress with a normal mood and affect with an independent gait. Upper and lower extremity strength is 5/5. It is unclear if she has tried using ice/heat alternately, swimming or whirlpool therapy or other supportive means to treat some persistent neck pain complaints. In addition, topical analgesic rub such as Mineral Ice or BenGay can be used to help take care of myofascial type of pain complaints. There is no specific pain rating of 0 to 10 pain scale for comparison between visits. Her day to day activities or how she spends time during a typical day are not included for review. Often a daily log of activities as part of a pain diary is useful to review especially before embarking on needle type of treatment approaches..

Given the information presented, I am unable to certify injection therapy at this time. Review of medical literature also notes the controversial nature of trigger point injections. Regardless, trigger point injections are not recommended as sole treatment and multiple authors and researchers do not recommend them for treatment especially without specific outcome goals. Randomized clinical trials have also been inconclusive in demonstrating their effectiveness noting instead that psychosocial factors may contribute to muscle tension and increase in pain and particularly anxiety. Consequently, other methods of treatment including behavioral health in improving a coping mechanism are often equally effective.

IRO Physician Reviewer #1778
Board Certified in Physical Medicine and Rehabilitation
Texas Medical License confirmed