MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: January 22, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Trigger point injections total of 3 to between neck and upper back area.

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

M.D., Board Certified in Neurology.

REVIEW OUTCOME

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

[X] Upheld	**(Agree)**
[ ] Overturned	(Disagree)
[ ] Partially Overturned	(Agree in part/Disagree in part)

The requested service, trigger point injections total of 3 to between neck and upper back area, is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 12/30/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 12/30/11.
3. Notice of Assignment of Independent Review Organization dated 1/02/12.
4. Pre-Authorization Form dated 11/18/11.
5. Medical records fromDO dated 8/15/11, 9/08/11, 1/14/11 and 12/22/11.
6. Operative report dated 9/07/11 and 11/02/11.
7. MRI of the cervical spine, without contrast, dated 7/05/11.
8. Imaging of the left shoulder dated 3/22/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained a work injury on xx/xx/xx when she was hit by a forklift. Per the medical records, since that time, she has had persistent neck, shoulder and arm pain despite conservative care. The patient has been diagnosed with chronic neck pain syndrome associated with degenerative arthritis of the cervical spine, status post traumatic fall injury. On 11/02/11, the patient received injection of contrast with performance of epidurogram and injection of corticosteroid and local anesthetic solution. In a pre-authorization form dated 11/18/11 requesting trigger point injections, the provider noted that the patient has notable trigger point tenderness and jump signs throughout the neck and upper back area consistent with this disease state. Supplemental treatment with exercise therapy and muscle relaxants is being utilized as well. The Carrier indicates that there is no objective documentation provided with regard to the failure of the patient to respond to conservative measures such as physical therapy, stretching exercises and oral pharmacotherapy.

At issue in this case is whether the requested service, trigger point injections total of 3 to between neck and upper back area, is medically necessary for treatment of the patient's medical condition.

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

Per the Official Disability Guidelines (ODG), trigger point injections 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) [Trigger point injections] 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."

In the case of this patient, she was started on Zanaflex on 11/14/11. On that same date, the provider indicated that trigger point injections would also be requested. Thus, the trigger point injections were proposed before the patient's response to this medication could be assessed. In addition, review of the submitted medical records reveals no documentation of completion of a stretching exercise program. All told, the submitted evidence does not demonstrate that ODG Criterion #3 for trigger point injections has been met. Based upon the documentation provided, there has been an insufficient trial of medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants to control pain. Therefore**,** I have determined that the requested service, trigger point injections total of 3 to between neck and upper back area, is not medically necessary for treatment of the patient's medical condition.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)