



Notice of Independent Review Decision

April 8, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Trigger Point Injection Bilateral Trapezius 20553, J3490, J3301, A4550

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

American Board of Physical Medicine and Rehabilitation with Subcertification in 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 medical necessity exists for each of the health care services in dispute.

IRO REVIEWER REPORT - WC

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- 8-9-12, office visit.
- 9-14-12, office visit.
- office visits on 9-29-12.
- 10-4-12 Behavioral health pre-authorization.
- 11-8-12, office visit.
- 1-3-13, office visit.
- 1-30-13 UR.
- 2-7-13 office visit.
- 3-4-13 UR.
- 3-4-13, phone conversation.
- 3-20-13, office visit.
- 3-21-13, office visit.

PATIENT CLINICAL HISTORY [SUMMARY]:

8-9-12, the claimant completed examination with distress, he is experiencing severe pain, decreased range of motion and muscle weakness to the cervical spine. He also has headache with frequent bouts of dizziness, balance issues, slow speech, cognitive issues and constant ringing of the ears. He has mild low back pain. Medications include Ziac, Norvasc, and Hydrocodone. It is recommended the claimant be referred to pain management specialist for medication management. He also recommended referral to a neurologist for vestibular rehabilitation or recommended treatment.

9-14-12, the claimant is a pleasant gentleman who presents to with the chief complaint of chronic, persistent neck, head, and upper back pain associated with poor memory, poor concentration, and depression having sustained a severe fall

IRO REVIEWER REPORT - WC

injury while at work on xx/xx/xx. The patient was in a good state of health and pain free when he fell over 14 feet while loading. He lost consciousness and awakened later that day in the hospital with severe chest pain and coughing up blood. He was evaluated and treated for concussion and head injury which continues here today. The patient reports he had MRIs and CAT scans consistent with fractures at the C6 and T12 levels. He currently grades his neck and head pain as 10/10. He states he has visual disturbances. He gets feared quite easily and he feels depressed all the time. In fact, a pain related stress inventory filled out today was remarkable for 0 of 20 true responses suggestive of moderate reactive depression and anxiety associated with this pain complaint. He admits to headaches on almost a daily basis and often has weakness in his arms and hands. He states his ears are often ringing. MRI of the cervical spine was reportedly remarkable for a herniated disk. The patient was recently referred for medication management and treatment of his ongoing depression. The patient also admits to occasional low back pain currently 4-5/10. Valsalva maneuvers are mildly provoking for neck, shoulder, and arm pain. On exam, this is a pleasant, middle-aged gentleman with notable hearing deficit, inability to concentrate and poor memory. He walked with an upright but slow physiologic gait. Normocephalic/atraumatic. Neck was supple with decreased left and right rotation at 40 and 50 degrees, respectively. He had a positive Spurlings test in neck with moderate mid cervical interspinous tenderness. Hoffman's tests bilaterally were unremarkable. No sudomotor or vasomotor changes were noted. He had good grip strength. He had normal biceps, triceps and muscle strength testing. Pinprick sensation was preserved. Trigger point tenderness in the posterior cervical, interscapular, and rhomboid regions was noted. He had mild facet tenderness at the C2-C3 and C3-C4 regions as well. He had some mild lumbar interspinous tenderness. Toes were downgoing. Pinprick sensation was preserved. Straight leg raising sign testing was unremarkable. Patrick's test at both hips was unremarkable. Plan: Combination of Zoloft, Amitriptyline, Hydrocodone, smoking cessation. His intake urinalysis was consistent with the agents reported to us. THC positive was advised and counseled for. We will certainly repeat this in the future.

office visits on 9-29-12. The claimant reports several bouts of depression over the past week. The evaluator recommended formal psychological evaluation with testing.

10-4-12 Behavioral health pre-authorization.

11-8-12, the claimant presents today with continued cognitive disorders. His urinalysis on initial evaluation was consistent with the agents reported to him. He suggested he write down the names of all his medicines as he is having difficulty remembering these. He is apparently under a neurologist's care receiving Trileptal. Additionally, he is receiving anxiety medication and an antihypertensive from the family physician. He feels the Vicodin has not been strong enough. He is citing myofascial pain in his neck and upper back area described as knife like. This is

IRO REVIEWER REPORT - WC

consistent with posttraumatic myofascial pain syndrome and cervicogenic headache. As a result, we are going to add Neurontin 400 mg t.i.d. to his Vicodin 5 mg tid. He will give him one refill or a two-month supply. He is taking these medicines from this office this office only. Continued neurologic evaluation per his referring physician was advised. If his trigger areas continue, then trigger injection therapy may be advised in the future. He did have jump signs in these areas

particularly in the cervical, interscapular, and rhomboid regions

1-3-13, noted he continued to treat him for chronic pain syndrome following traumatic head injury and secondary myofascial pain syndrome in his neck and upper back area. He is being treated by a neurologist with Trileptal. In the meantime, he feels the combination of Neurontin, Hydrocodone, and Amitriptyline at night has improved his sleep, pain tolerance, and mood control. Unfortunately with this recent weather changes he feels stiff all the time. He had marked decreased neck range of motion and trigger point tenderness in both trapezius, right greater than left areas associated with decreased range of motion. He also has trigger point tenderness extending into the interscapular rhomboid regions with positive jump signs. He does not have radicular symptoms down either arm or hand. He has decreased neck range of motion as well as headaches now on a daily basis. At this point, he will recommend trigger injection therapy in his neck and upper back area as outlined above, jump signs were elicited. He will go ahead and schedule him for this pending insurance authorization. In the meantime, continue walking, exercise, and rehabilitative efforts were encouraged, and he will schedule him for his pending insurance authorization.

1-30-13, UR non certification for bilateral trigger point injections trapezius. He noted that ODG only supports trigger point injections as an adjunct to a program of exercising and/or stretching. This request cannot be supported.

2-7-13, the claimant presents today for continued care regarding his traumatic head injury, post-concussion syndrome or persistent neck and upper back pain complaint. He is disgusted. He does not understand why this gentleman who has had a significant head injury with persistent neck and shoulder pain is being seen by a Board Certified Fellowship Trained Pain Specialist is being denied care. He looked with humor that the peer doctor who denied simple trigger injection therapy for myofascial pain, which has been well established and consistent with the ODG guidelines and if this is not radiculopathy, the patient has failed prior rehabilitative, medical and treatment options. The patient has a twitch response, what would I call a jump sign, which is better nomenclature in the literature as described is not being approved in a timely manner. Hip pain has persisted at least 6 months or more. This procedure should be considered both diagnostic and therapeutic. In the meantime, he will have him to continue on oral medications, which he does not want to take forever. He discussed exercise therapy, nutritional

IRO REVIEWER REPORT - WC

balance and proper sleep. He is under his neurologist's care for his head injuries. He is taking Hydrocodone a low dose of 5 mg 2 to 3 times per day and Neurontin 400 mg t.i.d, with fair result. His sleep is improved with Amitriptyline at night for the tension components of his neck pain complaint. As a result, we are now having a resubmit for trigger injection therapy for this gentleman's neck, posterior cervical,

interscapular, and trapezius regions. Slump signs were elicited in at least four places today with reproduction of his neck pain complaints. He could not be any more clear as to this patient's condition. It was outlined on his initial visit. It is being outlined once again in his notations. Hopefully, a wise decision will be made to allow his patient to improve and get back to his former pain-free status, which is to be reiterated. He did not have pain before his head injury from his work.

3-4-13 UR non certification for trigger point injections at bilateral trapezius. He noted that this request was outside of guideline recommendations.

3-4-13 notes he just got off the phone with a very pleasant regarding this patient's myofascial trigger point pain in his neck and upper back area following a concussion injury. This was outlined both by his previous physician. This gentleman has failed conservative, rehabilitative and medical treatment options that is why he was referred to me. Already xx mood, affect, and sleep have improved with Amitriptyline 20 mg at night, Zoloft 50 mg q.a.m. and he is taking his Neurontin with Vicodin, both indicated for myofascial pain complaints. He did have trigger points notable both on his previous exams and my current exam. As a result, we are recommending trigger injection therapy to be used as soon as possible. Further delays in this treatment will only lead to more refractory pain complaint.

3-20-13, the claimant has post concussion syndrome. He presents with a prior history of seizure disorder currently on Trileptal. The evaluator recommended Urine toxicology, video nystagmography, and post urography. The claimant is to start Trileptal 300 mg two times a day.

3-21-13, the claimant presents today further care regarding his head injury, subsequent disk herniation and chronic neck pain, which he believed should respond to cervical epidural blockade. He is still having decreased neck range of motion with moderate mid cervical interspinous tenderness. He had trigger point tenderness in the cervical and upper thoracic regions. This gentleman has failed previous medical treatment options. Cervical epidural blockade is an excellent avenue for him to consider given his persistent headache, neck pain and tightness in his cervical spine. In the meantime, he has continued with his Neurontin, his weak narcotic analgesic as well as care by his neurologist, which includes the combination of Trileptal with Gabapentin. He will arrange for cervical epidural blockade pending insurance authorization. Apparently, the trigger point injections were denied, even though the myofascial pain is also a significant component of his ongoing pain

IRO REVIEWER REPORT - WC

complaints.

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

Based on the records provided, the trigger point injection is reasonable and appropriate. The exam clearly shows trigger points and he has failed conservative care. Therefore, the request for Trigger Point Injection Bilateral Trapezius (20553, J3490, J3301, A4550) is reasonable and medically necessary.

Per ODG 2013 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 Myofascial 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

IRO REVIEWER REPORT - WC

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:

IRO REVIEWER REPORT - WC

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.

IRO REVIEWER REPORT - WC

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)