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Notice of Independent Review Decision

July 5, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Trigger point injections to be done in doctor's office (20553, J3490, J3301 and A4550)

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

Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME:

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

X Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Office visits (04/27/07 – 05/16/13)
- Diagnostics (08/15/11)
- Utilization reviews (05/31/13 – 06/07/13)

Dr.

- Office visits (04/27/07 – 06/06/13)
- Diagnostics (08/15/11)
- Utilization reviews (05/31/13 – 06/07/13)

TDI

- Utilization reviews (05/31/13 – 06/20/13)

ODG (Work Loss Data institute, Web-based version) criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who on xx/xx/xx, was helping when a master pack did not stop at the checkpoint. He went to pull the emergency button and eventually fell, jerking him down injuring his neck, shoulder, arms and hands.

2004 – 2006: No records are available.

2007: On April 24, 2007, the patient was seen by D.O., for complaints of chronic and persistent neck, bilateral shoulder, arm and hand pain associated with numbness and weakness. The patient reported that subsequently after the injury, he had developed an injured disc which required a two-level cervical disc fusion in 2005, without any relief. The pain was associated with weakness, weight gain and sleep loss. He presented to Dr. with a supportive wife and indeed his pain-related stress inventory filled out was remarkable for 14 to 20 true responses suggestive of moderate reactive depression and anxiety as it related to chronic pain. Valsalva maneuvers were moderately provoking. The patient admitted stiffness and decreased energy and interest in sexual activities or former recreational activities which he enjoyed. History was positive for bronchial asthma. The patient was utilizing hydrocodone, ibuprofen, nabumetone, OxyContin and Wellbutrin. Surgical history included neck and knee surgery without anesthetic sequelae. On examination, the neck was supple with decreased left rotation at 30 degrees and right rotation at 40 degrees. He was able to bring his chin within half inch of his chest. Range of motion (ROM) posteriorly was limited to 30 degrees with reproduction of neck, shoulder and upper back pain complaints. Spurling's testing was mildly positive. He had multiple areas of trigger point tenderness throughout the interscapular and rhomboid regions. He had decreased pinprick sensation in the C5-C6 distributions bilaterally. Deep tendon reflexes (DTRs) were normal and reflexic. There was no sudomotor or vasomotor changes. There was give way weakness to shoulder abduction, biceps and triceps. Trigger point tenderness was noted in the interscapular and rhomboid regions. Straight leg raising (SLR) was 90 degrees bilaterally without sciatic stretch signs. Dr. diagnosed post cervical laminectomy pain syndrome with recurrent cervical radiculopathy bilaterally, chronic myofascial pain syndrome and moderate-to-severe reactive depression in a chronic pain state. He stated the patient's prognosis was fair to good. He went over the details with the patient and encouraged him on active ROM and rehabilitative efforts in conjunction with interventional pain care such as cervical catheter placement with lysis of adhesions, injections of corticosteroid and local anesthetic with further adjustment of appropriate antidepressant and neuropathic support. He suggested that the initial medical management would include mixed norepinephrine and serotonin Effexor. It should give the patient analgesia, improvement of mood and improved daytime energy. He discontinued Wellbutrin and started clonazepam at night to help with neuropathic pain and sleep. Lyrica and Norco were also added and the patient was advised to continue with his OxyContin. Dr. felt that MS Contin could be added in the future on a steady basis for its anxiolytic effects.

2008 – 2010: No records are available.

2011: On August 1, 2011, M.D., noted that the patient's issue began on December 27, 2004. The patient tried to control a large object on a conveyor belt when he lost his balance causing him to pitch forward and fall forward striking his head on the edge of a crate. The patient had immediate onset of cervical pain with radiation to the upper extremities. He was ultimately diagnosed with a herniated disc in the cervical spine. The patient underwent a fusion procedure at C5-C6 in 2005. He was initially doing well after the first several months, but over the last year he had increasing pain in the cervical spine with radiation to his left upper extremity. His last treatment was a cervical epidural steroid injection (ESI) approximately one year ago, which provided him with several weeks of good relief. Examination of the cervical spine revealed decreased flexion by 20%, extension by 30% and rotation to the right and left by 30%. Neurological examination revealed strength to be 5/5 proximally and distally, with the exception of the right triceps, which was graded at 4/5. Sensation was subjectively decreased in digits one through three on the left, but otherwise was within normal limits. DTRs were 2+ bilaterally biceps, absent at the bilateral triceps, 2+ at patellae bilaterally and absent at the bilateral ankles. Dr. diagnosed previous C5-C6 cervical fusion, rule out C6-C7 radiculopathy and rule out peripheral nerve entrapment/median nerve entrapment. He discussed that the patient had increase in symptoms over the last year radiating to the left upper extremity with numbness and tingling particularly of digits one through three. This could indicate that the patient was now developing radiculopathy below the level of fusion at C6-C7 and that was correlated with the loss of reflexes at the bilateral triceps and weakness at the right triceps. Other possibilities would be a median nerve entrapment as sensory loss was mostly in the median distribution. He ordered electrodiagnostic studies of the left upper extremity.

On August 15, 2011, electromyography/nerve conduction velocity (EMG/NCV) of the left upper extremity revealed left C7-C8 cervical radiculopathy. There was no NCV evidence of generalized peripheral neuropathy, plexopathy or entrapment.

2012: On December 20, 2012, the patient presented to Dr. for a follow-up of post cervical laminectomy pain syndrome and persistent radiculopathy based on the surgical findings and based on the clinical presentation confirmed and corroborated with EMG/NCV testing. He continued to have decreased neck ROM and had myofascial trigger point tenderness in the neck and upper back area. Medications provided him fair relief. The patient reported that the injection and therapy had helped him to maintain his function, decrease his pain levels and allowed him to continue on with his daily activities. The patient wanted to change his medications which he felt he had developed tolerance to. Dr. therefore switched him from Norco to Ultram and continued Lyrica and Zanaflex at night. He also suggested a daily walking exercise program and behavioral rehabilitative support. He encouraged on dietary changes and environmental changes.

2013: On January 17, 2013, the patient reported that weather changes had aggravated his neck symptoms and he could not perform his activities of daily living. He rated his pain at 8-9/10. The patient stated that the best treatment thus far had been interventional pain care, which had included cervical epidural blockades, utilizing lysis of adhesion techniques and injections of corticosteroid. This was consistent with the Official Disability Guidelines (ODG). Dr. noted that the patient's pain was higher than he had for quite some time and there was markedly decreased neck ROM and pinprick sensation at C5-C6 distribution. It had been over a year since the cervical epidural blockade had been performed. He thus recommended proceeding with the same as the patient had failed conservative, rehabilitative and surgical treatment options.

On March 18, 2013, Dr. noted trigger point tenderness in the neck and upper back associated with jump signs. The patient's intake urinalysis was negative for illicit drug use. He was able to walk with upright gait balance. His medications included Lyrica, Zanaflex and Norco. On further examination, there was decreased ROM of the neck with some mildly decreased grip strength on the left. Dr. scheduled the patient for trigger injection therapy as the patient's pain was confined to his neck and upper back area.

On May 16, 2013, the patient reported that his neck was tightening up. He again stated that the trigger injections provided to him a year and a half ago had relieved his neck pain allowing him to be more functional, more active and helped him with more than 70% of his pain. He was requesting similar treatment. Dr. wrote a letter denouncing apparently the peer review doctor's assessment which was inappropriate and blatantly erroneous. He stated that the patient was suffering from post cervical laminectomy pain syndrome and recurrent radiculopathy as evidenced by his EMG/NCV testing. He clinically had myofascial trigger point tenderness in the neck and upper back area associated with decreased ROM and jump signs. This was not to be confused with the cervical laminectomy pain syndrome. This was a secondary diagnosis. That was quite common that the patient's with primary injured work status requiring surgical intervention develop chronic pain syndrome associated with myofascial pain, which was secondary, but attributed diagnosis associated with his work injury. Dr. further stated that the patient should continue on narcotic analgesics. He would consider further treatments including antidepressant support in the form of Effexor. He further stated that the trigger injections in the cervical area were highly effective and was cost effective treatment for myofascial pain.

On May 18, 2013, Dr. noted that the medications had stabilized. The patient still had decreased ROM of the neck with some mildly decreased grip strength on the left. Dr. again suggested trigger injection therapy.

Per Utilization review dated May 31, 2013, the request for outpatient trigger point injections (TPIs) to the neck and upper back area was denied by M.D., with the following rationale: *"Claimant allegedly sustained strain injuries to the neck and shoulder in xxxx. Documented treatment to date has included anterior cervical discectomy and fusion at C4-C5 and C5-C6 in 2005, medications, physical therapy,*

TPIs and cervical epidural steroid injections (ESIs). Previous request for repeat TPIs was denied February 13, 2012, citing ODG (Work Loss Data Institute. Web-based version.) recommendations and noting insufficient documented objective evidence of current trigger points per physical exam, lack of a recent course of exercises or physical therapy, documented evidence of radiculopathy and lack of response to previous TPIs performed on April 4, 2005. Subsequent TPI requests have been administratively denied. May 16, 2013 provider note documented complaints of the neck tightening up. Provider stated that previous TPIs (date unknown) relieved neck pain more than 70% and allowed claimant to be more functional. Provider stated that claimant has myofascial trigger point tenderness to the neck and upper back area associated with decreased range of motion and "jump signs" (positive twitch response). Provider stated that pain was confined to the neck and upper back area. The updated clinical information and details concerning response to previous TPIs constitute a substantial change in condition. ODG (Work Loss Data Institute. Web-based version.) criteria for TPIs are not met. A recent course of exercises or physical therapy is not documented. Date and duration of response to the most recent set of TPI's are unknown. Non-authorization of this request is recommended"

On June 6, 2013, Dr. appealed for a reconsideration stating that the patient fitted the criteria for relapsing a recurrent pain.

Per reconsideration review dated June 7, 2013, the original decision of denial of TPIs was upheld by M.D. Rationale: *"ODG requires the presence of a discrete trigger point on physical exam with referred pain, and an ongoing functional restoration program. This has not been documented. I spoke with Dr. and he insisted that ODG are met because a trigger point was present on physical exam. He was augmentative, belligerent, and rude insisting that ODG are met. As noted above, there is no documentation of radiation of pain with palpation of the trigger point and no documentation of an ongoing functional restoration program. ODG are not met for the requested procedure."*

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

Patient meets criteria based on documented physical examination and verbal reports of relief of pain amounting to 70% following prior trigger point injections. A significant amount of time has passed since the prior trigger point injection. Thus, the request is appropriate according to ODG guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES