



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 9/8/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of interspinous ligament trigger point injection LT C7-T2.

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

The reviewer is a Medical Doctor who is 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)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of interspinous ligament trigger point injection LT C7-T2.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured at work on xx/xx/xx while reaching overhead. The worker received chiropractic care, medications and physical therapy for rotator cuff sprain, disorder of the bursa and tendons of the shoulder, and thoracic sprain. According to records submitted the worker had been seen in February 2009 by a spinal surgeon who found no indication for surgical care and recommended a pain management consultation. In May 2009 the worker was seen by a pain management specialist. Attempts were made for enrollment into a chronic pain management program. On a functional capacity examination the worker

performed at a PDL of light and on August 06, 2009 an impairment rating of zero percent was given.

On 02/18/2014, evaluated the worker who reported aggravation of the old injury. She complained of neck, shoulder and thoracic spine pain. recommended Robaxin, a Medrol Dosepak, and physical therapy. Therapy proceeded as planned. On the physical therapy note of 03/11/2014 the worker had improvement of spontaneous motion of the neck and shoulders and was progressing well. On the follow-up visit on 03/12 2014 noted that the symptoms had decreased in response to therapy.

On 04/04/2014 a referral was made for anesthesiology pain specialist consultation. In a note dated May 8, 2014 stated that on April 17, 2014 the pain management specialist had recommended injections to the cervical spine and the shoulder.

On 05/08/2014, the worker reported that the spine symptoms had decreased. The left shoulder pain was at level 4 on the visual analog scale. Numbness and tingling remained the same. Weakness remained the same. With respect to the thoracic spine the symptoms had remained the same. On this examination there was muscle spasm at the medial superior aspect of the left scapula. He gave an injection of 40 milligrams of Depo-Medrol and 3 milliliters of 1 percent lidocaine.

On the follow-up evaluation on 05/22/2014 noted that the worker reported that the shoulders and back had done better until the last few days. He injected 3 milliliters of 1 percent lidocaine and 20 milligrams of Depo-Medrol to the trigger point superior and medial to the medial border of the scapula. Afterward the worker reported immediate improvement of the symptoms. On the physical therapy note on 06/03/2014 the worker participated in therapy but required frequent therapeutic rests because of pain. She reported decreased pain after trigger point release to the left upper trapezius and levator scapulae muscles.

On 06/05/2014 the worker was evaluated. The worker complained of non-radiating neck pain. The worker had had multiple physical therapy sessions with minimal or no help. No medication helped. Pain was aggravated by standing, sitting, walking, and turning her head. She continued to work full-time. Her current medications were tramadol, Robaxin, Flexeril and Norco. On physical examination there was interspinous ligament pain at C7- T1 and T1-T2. The diagnosis was cervical strain 847.0 and thoracic strain 847.1 recommended interspinous ligament injections under fluoroscopy. The request was submitted 06/12/2014. The requested interspinous ligament trigger point injections were non-authorized on June 17, 2014. The non-authorization decision was upheld on appeal on June 19, 2014.

On the physical therapy daily note of June 19, 2014 the therapist noted that the worker had not made much progress with therapy and that her left shoulder

active range of motion had decreased from 109 degrees of flexion down to 90 degrees and from 97 degrees of abduction down to 52 degrees. The worker was issued a home exercise program and received education and training. She received therapy modalities and neuromuscular reeducation. She performed dynamic activities and participated in back education. She was unable to perform lifting activities during therapy.

On June 20, 2014, a request was submitted for 6 more therapy treatments to the left shoulder, with the total PT/OT visits approved to date listed as 20 treatments. On June 25, 2014 the physical therapy daily note indicates that the worker did complete all activities without complaints. These included therapeutic exercises, neuromuscular reeducation and therapeutic activities.

On the status report and follow-up evaluation on July 29, 2014 the worker reported that her shoulder was doing much better and that her range of motion was much better. She was working with restricted duty. Pain was noted to be along the medial aspect of the left scapula. On examination there was decreased range of motion of the cervical spine. There was negative Spurling's test. Upper extremity vascular examination remained intact. Deep tendon reflexes were normal. Sensation was reported to be decreased in the C6 nerve root distribution.

Muscle strength was normal. The shoulder examination revealed positive left impingement with abduction increased to 60 degrees and flexion about the same at 70 degrees. Thoracic spine range of motion revealed full range of motion, no obvious deformities.

DIAGNOSTIC STUDIES

03/18/2014: MRI Cervical Spine Without Contrast.

- Straightening of the cervical lordosis without spondylolisthesis, with differential considerations including muscle spasm, anatomic variation or patient positioning. Clinical correlation is advised. Cervical cord signal is normal.
- No focal protrusion, central canal stenosis, cord flattening or osseous foraminal compromise involving the cervical intervertebral disc levels. Minimal annular bulge and C5-C6 and at C6-C7.

03/18/2014: MRI of the shoulder without contrast (left).

- Supraspinatus and infraspinatus tendinosis with short segment, linear, low-grade intrasubstance delamination tear involving the conjoined portion of the rotator cuff. Mild bursal tendon surface fraying of the supraspinatus without evidence of fluid filled partial thickness articular surface tear or full thickness tear of the rotator cuff. No muscular atrophy. Mild overlying bursitis.

- Mild acromioclavicular joint capsule hypertrophy. Shallow lateral downsloping of the type II acromion process. Osseous acromial outlet fails to cause mass effect upon the supraspinatus musculotendinous junction in the position of adduction.
- No displaced labral tear. Biceps labral complex and biceps tendon appear intact. Minimal, nonspecific increased glenohumeral joint fluid.

03/18/2014: MRI thoracic spine without contrast.

- Mild facet arthropathy at T10-T11 and at T11-T 12.
- No focal protrusion, cord flattening or central canal stenosis involving the thoracic intervertebral disc levels. Thoracic cord signal is normal.

There is no evidence of thoracic vertebral body compression, deformity or spondylolisthesis.

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

The records do not definitely document a myofascial pain syndrome of the cervical spine. There was no mention of hyperirritable foci located in palpable taut bands of skeletal muscle, with local twitches in response to stimuli to these bands. The painful areas palpated on the cervical spine, as described, do not meet the ODG definition of trigger points. Physical examination findings included cervical paraspinal muscle spasms with no mention of trigger points. The records do include information about persistent pain in the left shoulder and a trigger point superior and medial to the medial border of the scapula, treated with an injection on 05/22/2014 and with physical therapy for trigger point release to the left upper trapezius and levator scapulae muscles on 06/03/2014. With the exception of chin tucks, physical therapy notes did not mention aggressive stretching, therapeutic exercises or intensive myofascial interventions directed to the cervical spine. In the June 20, 2014 a request was submitted for 6 more therapy treatments for the left shoulder but not the cervical spine.

ODG –TWC Integrated Treatment/Disability Duration Guidelines, Pain (Chronic), (updated 07/10/14):

Trigger point definitions: A trigger point is a hyperirritable foci (sic) 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

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.

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.

From the Colorado Division of Workers' Compensation, Medical Treatment Guidelines, Rule XVII, Cervical Spine Injury, 12/01/01. RULE XVII, EXHIBIT E, cited in the ODG Guidelines:

There is no indication for conscious sedation for patients receiving trigger point injections. The patient must be alert to help identify the site of the injection.

According to the ODG, the requested procedure is not medically necessary.

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)**