

CASEREVIEW

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[Date notice sent to all parties]: May 20, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder Trigger Point Injection Therapy Under Fluoroscopy, IV Sedation
20553, J3301, A4550

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

This physician is a Board Certified Anesthesiologist with over 6 years of experience.

REVIEW OUTCOME:

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

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx while working. The claimant tripped on a metal object and fell causing a puncture wound to his abdomen and colon, as well as fractured ribs. He also had intense pain in his right shoulder, arm and hand after awakening from a comma due to the injury. He was treated for the rib fractures including 3, 5, 6, 7, 8 and 9 on the left and the abdominal wound.

On July 19, 2014, the claimant present for follow-up who reported complaints of worsening left-sided anterior rib pain. On examination of the chest revealed tenderness of the left anterior ribs just lateral to the sterna border. Right shoulder had some crepitation with range of motion. Impression: Rib fractures with continuing rib pain, shoulder pain, COPD, morbid obesity. Plan: Chronic pain management program. Hydrocodone-acetaminophen 10-300 MG.

On August 16, 2014, the claimant presented requesting a TENS unit for his right shoulder and more narcotics since he stated he needed more than 2 per day. Examination of the right shoulder revealed painful ROM and generalized tenderness of the right shoulder. There is crepitation noted. Impression: Right shoulder strain from therapy. Left rib fractures, left pleural effusion, COPD, left lower lobe pneumonia. Plan: Chronic pain management program, TENS unit for his shoulder, x-ray of his right shoulder, MRI of his right shoulder, Hydrocodone-acetaminophen 10-300 mg, Meloxicam 15 mg.

On August 21, 2014, MRI Right Shoulder, Impression: 1. Prominent partial thickness tear involving the supraspinatus and infraspinatus tendon. No significant full thickness tear. There is prominent adenopathy. 2. Partial thickness tear involving the subscapularis tendon with borderline medial subluxation of the superior biceps tendon from the bicipital groove. There is tendinopathy involving the long head biceps tendon, but I do not see a full-thickness tear. 3. Osteochondral lesion involving the medial humeral head with articular cartilage defect. This measures approximately 1.5 cm in diameter. 4. Biceps tendinopathy. 5. Prominent hypertrophic degenerative changes involving the AC joint. 6. Small glenohumeral joint effusion with a moderate amount of fluid in the subscapularis region.

On November 25, 2014, the claimant presented for an initial pain evaluation. The claimant reported moderate anxiety and depression over the injury. His right shoulder pain was rated a 6-8/10 and he reported often dropping things, weakness and decreased ROM. He complained of a burning, shooting pain across his abdominal and chest wall cavity. Current medications included Hydrocodone 10 mg 4 times a day and Meloxicam. On examination he was a 5'11" and 330 pounds. He walked with an antalgic limp and gait. Inspection about the left rib margin revealed costal tenderness on the anterolateral aspect at the 6, 7, and 8 ribs. He had some mild tenderness in the upper abdominal area. There was no guarding or rigidity. He had marked decreased range of motion about the right shoulder with a drop test positive. He had difficult internal and external rotation with pain over the bicipital groove area as well as the AC joint. His ROM was 50% of normal. Motor and sensory testing was otherwise unremarkable, some mild trigger points in his neck and upper back area also noted. Trigger point tenderness in the cervical, interscapular regions were noted. Diagnosis: 1. Traumatic injuries following work accident with continued left rib and abdominal pain consistent with intercostals neuralgia following rib fractures and abdominal wound. 2. Neuropathic pain secondary to #1. 3. Chronic right shoulder pain following traumatic work accident cannot rule out internal derangement consistent with rotator cuff tear. 4. Moderate reactive depression, anxiety and chronic pain state. 5. Persistent myofascial pain of the cervical, upper thoracic regions associated #1 and #2. Plan: While waiting on an orthopedic evaluation of the right shoulder, recommend a combination of neuropathic, somatic analgesics, including ibuprofen 600 mg and gabapentin 600mg. Also Ambien at night and Tylenol #4 for breakthrough pain.

On December 10, 2014, the claimant presented for follow-up. He reported fair improvement of his left chest and wall pain. His main complaint was his right shoulder. There was trigger point tenderness in the shoulder, deltoid as well as bicipital groove. Recommendation of trigger injection therapy.

On February 4, 2015, the claimant presented for follow-up. He continued with moderate left chest wall pain. The injection therapy had been denied. The claimant was reported to be working on smoking cessation. He was compliant with medicines including gabapentin and Norco. He reported still having difficulty sleeping and mood issues. Due to the persistent myofascial pain as well as intercostals neuralgia, intercostal nerve blocks as well as trigger point injections were recommended. Wellbutrin in the morning and Restoril at night was prescribed. It was also recommended he continue exercise and rehabilitative efforts.

On March 4, 2015, the claimant presented for follow-up. He had exquisite tenderness over the right shoulder area with trigger points as well as some mild tendinitis at the bicipital groove. Recommended a round of NSAIDs in conjunction with weak narcotic analgesic as well as localized cream. Also recommended trigger injection therapy into the right shoulder.

On March 24, 2015, UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced above, this request is non-certified. The patient is currently not taking muscle relaxants. In addition, there is no evidence of continued ongoing home exercises or stretching in the submitted records supporting the use of TPI for pain management.

On April 2, 2015, the claimant presented for follow-up. Trigger points were identified in the posterior shoulder and upper neck area. ROM exercises were described today, jump signs were list in the posterior deltoid interscapular as well as over subacromial site reproducing his shoulder pain complaint. Trigger injection therapy recommended as the claimant is requiring a combination of NSAIDs, neuropathic as well as occasional weak narcotic analgesia. He was reported to be performing home exercise.

On April 23, 2015, UR. Rationale for Denial: The previous noncertification is supported. Additional records included an evaluation on April 2, 2015. There is no documentation of any use of muscle relaxants. The physical examination did not show circumscribed trigger points with evidence on palpation of a twitch response and referred pain. There was no documentation of why the claimant requires fluoroscopy and IV sedation for the trigger point injections. The number of injections was not documented. Official Disability Guidelines would only support two to three injections per procedure. The request for an appeal of right shoulder trigger point injection therapy under fluoroscopy with IV sedation is not certified.

On April 24, 2015, the claimant presented for follow-up. was still recommending trigger injection therapy as all other physical therapy and rehabilitative efforts had been exhausted. Trigger point were identified across the right lateral shoulder and chest wall area. It was noted that they were not requesting IV sedation.

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

The previous adverse determinations are partially overturned. Given that the claimant has several trigger points on physical examination and other conservative measures and therapy have been attempted without success, there is justification for the requested trigger point injections. Per ODG, there should be two to three per procedure. However, there is not justification for the IV sedation. Therefore the request for Right Shoulder Trigger Point Injection Therapy is certified however, the request for IV sedation is non-certified.

PER ODG:

Criteria for the use of TPIs (Trigger point injections):

TPIs with a local anesthetic may be recommended for the treatment of 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.

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)**