14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

DATE OF REVIEW: 9/05/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

"Repeat Trigger point injection for the XX region prior to the XX epidural, XX epidural via XX under XX" for the patient.

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

M.D. Board Certified in Orthopedic Surgery and Sports 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)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XXXX with a work-related XX XX injury described as being related to a XXXX. The included clinic note is from XXXX. The patient carries the diagnoses of XX XX syndrome, XX XX and XX, XX XX. The patient continued to complain of severe XX XX pain and is described as having XX symptoms. This is being treated with XX and XX. XXXX has tried other medications that have been stopped due to side effects. XXXX has had multiple XX XX surgeries including a XX XX stimulator in the past. XXXX has recently had three sets of trigger point injections in the XX XX with reported short-term symptom improvement but no decrease in the use of pain medications. On exam XXXX is noted to have severe tenderness in the XX area. XXXX has XX XX straight leg raises. No strength deficits are noted. There is decreased sensation noted in XX XX but not the

specific location. The requested plan at this point is for repeat trigger point injection for the XX region and for a XX epidural injection via XX under fluoroscopy.

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

Per ODG references, the requested "Repeat Trigger point injection for the XX region prior to the XX epidural, XX epidural via XX under Fluoroscopy" is not medically necessary. This request has been correctly denied twice previously. With regard to the trigger point injections, the patient does not meet ODG criteria in that XXXX is not diagnosed with myofascial pain syndrome. XXXX also has had 3 sets of trigger point injections with only short-term response which by recommendations would suggest evaluating that the diagnosis is correct or looking for other treatment modalities. XXXX also has failed to show reduction in pain medication use after injection even when they were said to be working which would not indicate that much reduction in XXXX symptoms. Regarding the epidural injection, XXXX does not have documented objective evidence of specific XX on physical exam and there is no imaging to support the diagnosis of XX. In addition, there is no documentation available of any conservative measures other than medications and injections that have been tried up to this point.

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 KNOWLEDGE BASE
- ☐ 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