# Becket Systems

**An Independent Review Organization**
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## *Review Outcome*

***Description of the service or services in dispute:***

XX XX injections / XX XX injection for XX XX, and XX XX XX, XX times
XX XX XX injection, XX or more muscle groups
XX XX XX, XX
XX XX

***Description of the qualifications for each physician or other health care provider who reviewed the decision:***

Board Certified Neurology

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

☐ Overturned (Disagree)
☑ Upheld (Agree)
☐ Partially Overturned (Agree in part / Disagree in part)

***Patient Clinical History (Summary)***

XX. XX XX is a XX-year-old, XX-handed XX who was diagnosed with XX without XX of XX, subsequent encounter. (XX.XX). On XX, XX was XX in the XX when XX XX, causing XX to XX. XX XX XX XX and XX on the XX.

On XX, XX. XX was seen by XX for XX and XX. XX presented for XX related to a XX sustained after a XX. XX had experienced constant XX since the XX. The symptoms remained the same since the accident. The symptoms started as XX behind XX XX XX that XX of XX XX and then XX of XX XX, XX, and XX. XX had XX every day, which lasted all day. The associated symptoms included XX, XX, XX, XX, and XX. XX often XX, but had XX. XX was able to XX per night. XX was XX because of pain. XX was unable to XX, as XX made XX XX worse. XX had XX on XX XX, as this would aggravate XX XX. XX was unable to participate in XX, as XX needed to XX, XX. XX had a history of XX prior to the accident. At that time, they were less severe and only occurred XX. XX also presented for XX, XX, XX of the XX, and XX of the XX of the XX. XX had increase in XX and XX since XX accident. There was an improvement in XX of the XX and XX of the XX of the XX. On examination, XX had tenderness to palpation along the XX XX XX and XX regions. The assessment was XX without XX of XX, XX of unspecified part of XX, XX of unspecified XX of XX, XX XX, and recurrent mild XX. XX delayed release and XX were started. It was noted that XX. XX would benefit from XX injection, XX injections, XX, and XX, given the XX tenderness with palpable twitch response and referred pain and XX tenderness with XX tenderness.

The treatment to date medications (XX, XX, and OTC medications), which were not helpful, XX therapy and acupuncture (did not help). XX felt drowsiness with XX.

An MRI was performed in XX, which was normal.

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# *Notice of Independent Review Decision*

Case Number: XX Date of Notice: 02/06/19

Per a utilization review decision letter dated XX and peer review dated XX, the requests for XX injection for XX, XX, XX times were denied by XX. Rationale: "XX injections were not recommended in the absence of XX pain syndrome. When this treatment was indicated, studies have not effectively demonstrated that ultrasound guidance for XX localization offers an advantage over simple palpation techniques. In this case, the request exceeds the frequency of therapy considered standard of care for the condition of regional XX pain. Thus the requested XX point injections times XX for XX is not medically necessary." The XX (XX) XX block for XX was not recommended until there were higher quality studies. There was only one limited trial. It had been suggested as a quick, minimally invasive procedure. A local anesthetic, XX, and also XX was introduced XX for topical administration. A new medical XX specific for medication XX to the XX was recently introduced, XX XX developed by XX. In this case, the request exceeded the frequency of therapy considered standard of care for the condition of a XX in consideration of the clinical information provided. Thus the requested XX were not medically necessary. The request for XX was denied with the following rationale: "The greater XX, therapeutic are under study for the treatment of XX and XX. There is little evidence that the block provides sustained relief, and if employed, is best used with XX. Current reports of success are limited to small, noncontrolled case series. Although, short-term improvement has been noted in 50-90% of patients, many studies only report immediate postinjection results with no follow-up period. In addition, there is no gold-standard methodology for injection delivery, nor has the timing or frequency of delivery of injections been researched. In this case, the request exceeds the frequency of therapy considered standard of care for the condition of a daily XX in consideration of the clinical information provided. Thus, the requested XX times XX is not medically necessary."

XX. XX wrote a letter on XX, documenting the medical necessity of XX injections, XX injections, and XX injections.

Per utilization review decision letter dated XX and peer review dated XX, the prior denial was upheld by XX. The rationale for XX injections: Per ODG (Official Disability Guidelines), XX injections (XX) were not recommended for the XX in the absence of XX syndrome. The records provided for the review did not readily demonstrate the presence of XX syndrome. There was no clear evidence of XX, nor has the said procedure shown to be a benefit in the management of a XX. In as such, non-certification is recommended." The rationale for XX (XX) blocks: "Not recommended until there are higher quality studies. The entry in ODG for this procedure (correctly) noted the absence of high-grade reliable evidence to support the use of the requested procedure in the management of a XX. Current literature does not otherwise permit conclusions about the utility of this service. Given the unproven nature of the service, noncertification is advised." The rationale for XX blocks: ODG states that the XX blocks remain "under study." ODG also notes, "Studies on the use of greater XX block for the treatment of XX and XX show conflicting results, and when positive, have found response limited to a short-term duration." Given the inconclusive utility of this procedure / techniques, the prior adverse determinations should be upheld, and non-certification is recommended."

***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

Given the documentation available, the requested service(s) is considered not medically necessary. I agree the requested XX and XX injections are not supported in this particular case. XX injections are not considered reliable treatment for XX and the evidence for XX and XX blocks is inconclusive at this time.

XX

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐

# *Notice of Independent Review Decision*

Case Number: XX Date of Notice: 02/06/19

DWC-Division of Workers Compensation

- ☐ Policies and Guidelines European Guidelines for Management of Chronic Low Back Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☐ ODG-Official Disability Guidelines and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☑ Peer Reviewed Nationally Accepted Medical Literature (Provide a description)

REFERENCES:

Robbins XX, et al. Trigger point injections for XX disorders: expert consensus methodology and narrative review. XX: The Journal of XX and Face Pain 2014; 54(9): 1441-59.

Arendt-Nielsen, Lars, et al. "Muscle Triggers as a Possible Source of Pain in a Subgroup of Tension-type XX Patients?." The Clinical journal of pain 32.8 (2016): 711-718.

- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

**Appeal Information**

You have the XX to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.