

True Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW:

AUGUST 9, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right C5-6 selective nerve root block

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

American Board of 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRI cervical spine 03/29/04

Medical Evaluation 06/01/04

Electrodiagnostic studies 10/11/04

Peer Review 08/18/06

Office Note Dr. 02/20/07 and 05/21/07

TWCC notes, 06/21/07, 07/05/07 and 07/30/07

Office notes Dr.: 05/05/04, 05/21/04, 08/04/04, 09/10/04, 10/13/04, 11/29/04, 01/10/05, 02/21/05, 04/10/05, 08/19/05, 10/26/06, 11/28/05, 01/03/06, 02/06/06, 02/13/06, 03/27/07 and 07/30/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a woman who was injured when falling on an outstretched right arm. Pain complaints involve cervical spine, right wrist, right cubital tunnel, elbow, forearm and arm. Question under review is the medical necessity for right C5-6 selective nerve root

block. Included in the records is an MRI of the cervical spine dated 3/9/04. This reading shows mild disc degeneration with annular bulging and marginal spurring at C5-6 and 6-7 with no neural impingement; a small central protrusion at C6-7 with no neural impingement. She had undergone right cubital tunnel release and continued to have diminished sensation in the ulnar distribution. An EMG was performed following the cubital tunnel. This showed some motor swelling at the bilateral carpal tunnels and swelling across the left ulnar nerve at the elbow and decreased amplitude of the right ulnar motor. Needle EMG findings were not included and were presumably not done. A detailed peer review was performed on August 18, 2006. Listed on the diagnostics were an EMG on 11/14/05 and an MRI of the cervical spine 11/21/05. An EMG was referenced as showing radiculopathy at C6-7 and 5-6 and possible C8-T1 as well as right ulnar neuropathy at the elbow and median neuropathy at the wrist. Dr. reviewed these findings and referred him to Dr. Cottler who recommended chronic pain and psychiatric treatment. An MRI of the cervical spine was referred to in this report showing disc herniations at C4-5 and 5-6 with borderline cord compression. The original data, however, was not included for either the EMG or the MRI of the cervical spine.

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

This is a woman who was injured when falling on an outstretched right arm. Pain complaints involve cervical spine, right wrist, right cubital tunnel, elbow, forearm and arm. Question under review is the medical necessity for right C5-6 selective nerve root block. Included in the records is an MRI of the cervical spine dated 3/9/04. This reading shows mild disc degeneration with annular bulging and marginal spurring at C5-6 and C6-7 with no neural impingement; a small central protrusion at C6-7 with no neural impingement. She had undergone right cubital tunnel release and continued to have diminished sensation in the ulnar distribution. An EMG was performed on 10/11/04 following the cubital tunnel. This showed some motor swelling at the bilateral carpal tunnels and swelling across the left ulnar nerve at the elbow and decreased amplitude of the right ulnar motor. Needle EMG findings were not included and were presumably not done. A detailed peer review was performed on August 18, 2006. Listed on the diagnostics were an EMG on 11/14/05 and an MRI of the cervical spine 11/21/05. An EMG was referenced as showing radiculopathy at C6-7 and 5-6 and possible C8-T1 as well as right ulnar neuropathy at the elbow and median neuropathy at the wrist. Dr. reviewed these findings and referred him to Dr. who recommended chronic pain and psychiatric treatment. An MRI of the cervical spine was referred to in this report showing disc herniations at C4-5 and 5-6 with borderline cord compression. The original data, however, was not included for either the EMG or the MRI of the cervical spine.

Reviewing Dr. last note from 5/21/07, there is no documentation of myetomal weakness, sensory symptoms in a nerve root pattern, Spurling's test reproducing radicular symptoms or reflex changes. There is no electrodiagnostic data that showed convincing evidence of radiculopathy. The only MRI report that was available for review in the in chart did not show any objective evidence of nerve root compression or foraminal narrowing.

Referring to the guidelines provided, radiculopathy must be documented by physical exam and corroborated by imaging studies and/or electrodiagnostic testing. There is insufficient documentation of physical exam or symptomatic evidence of radiculopathy or imaging studies and electrodiagnostic testing. The right C5-6 nerve block therefore cannot be certified.

Right C5-6 selective nerve root block is not found to be medically necessary.

Official Disability Guidelines 2007 Updates

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

- 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.
- 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
- 3) Injections should be performed using fluoroscopy (live x-ray) for guidance.
- 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.
- 5) No more than two nerve root levels should be injected using transforaminal blocks.
- 6) No more than one interlaminar level should be injected at one session.
- 7) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004)
- 8) Repeat injections should be based on continued objective documented pain and function response.
- 9) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.

The Reviewer performed a review on this case on August 9, 2007, upholding a previous denial of a right C5-6 selective nerve root block. Additional records have been made available for my review regarding this case.

Records include MRI of the cervical spine dated 11/21/05. These were read as disc herniation at C4-5 and C5-6. Specifically noted all levels including C7-T1, C6-C7, C5-C6, C3-C4, C2-C3, were patent neuroforamen bilaterally. At C4-5 axial images were degraded by motion and could not be adequately evaluated.

There is an EMG by M.D. 11/14/05, read as right ulnar neuropathy at the elbow. The Reviewer would not argue with this. There is a borderline delay of nerve conduction velocity at the elbow. She also notes median neuropathy at the wrist, mild, and the Reviewer does not see the basis for that diagnosis with normal sensory and motor latencies. On the needle EMG examination, she notes cervical radiculopathy at C6-7, 5-6 and T1. My reading would note the possibility of C8 radiculopathy in that there are fibrillations in two C8 muscles. There are no fibrillations or positive sharp wave findings in any C5-6 muscles. She does note polyphasic motor units in almost all muscles including with the exception of the triceps and pronator teres which are C7 muscles. In looking at this data, the Reviewer would see evidence only of C8 radiculopathy, but not C5-6 or C6-7. There is also an EMG by M.D. 10/11/04. The Reviewer has reviewed his data. He diagnoses bilateral median entrapment at the wrists, i.e. carpal tunnel syndrome. The Reviewer would agree with this, but not his assessment of severe findings. There is increased motor latency, but the Reviewer doesn't see any evidence of sensory involvement. The Reviewer also agrees with his diagnosis of left ulnar

neuropathy at the elbow. He does note bilateral ulnar sensory neuropathies with edema at the wrists and the Reviewer do not see any evidence of that. There are no needle exam results provided along with this study. There is a previous EMG report from 12/23/02 by Dr. He diagnoses right ulnar neuropathy at the elbow. He did do a needle examination with essentially normal findings. He notes poor relaxation in the cervical paraspinals and a few polyphasic motor units in the right triceps. This study shows no evidence of radiculopathy by my interpretations.

MRI of the right shoulder is included, showing mild to moderate acromioclavicular joint arthrosis and partial thickness bursal surface tear of the supraspinatus.

There is a functional capacity evaluation placing her in the light work status category with restricted repetitive reaching and limited overhead repetitive reaching.

There is also a current EMG by Dr. dated 07/30/07. This study shows normal nerve conduction studies. The Reviewer doesn't see evidence for mild median neuropathy at the wrists as she does. Needle examination showed the same results as her previous study with fibrillations and positive sharp waves in the right first dorsal interosseous and right extensor digitorum communis. She also notes polyphasic motor units in all muscles except the right pronator teres. She interprets this as C6-7 radiculopathy. The Reviewer's reading of these results would show the possibility of either C8 radiculopathy, lower trunk brachial plexus lesion and possibly some leftover changes from the ulnar neuropathy she had previously (first dorsal interosseous fibrillations). There were no findings whatsoever in C6 or 7 muscles. There were no actual C6 muscles tested. The pronator teres has both C6 and C7 innervation and this muscle was completely normal. Therefore, the diagnosis of C6 or C7 radiculopathy cannot be made based on these results.

Records from M.D. were provided. On 05/05/04, he notes she was 14 weeks status post right cubital tunnel release. Chief complaint was moderate mechanical pain with numbness, tingling, weakness, loss of coordination in right lateral elbow radiating to the forearm. 08/24/04 notes three level bulging disc C5 through 7 and Dr. recommended non operative treatment. 09/01/04 notes moderate mechanical pain in the right lateral elbow. 10/13/04 notes physical examination of the neck with normal findings, continued complaints of moderate mechanical pain in the right lateral neck and elbow. 11/29/04 shows similar complaints. 01/10/05 physical examination shows normal findings of the neck. 04/01/05 notes triggering in the left thumb, pain in the forearm and hand. 10/26/05 notes pain at ulnar, lateral neck and elbow. He notes positive compression test per cervical on the right side and diagnosis is cervical radiculitis. His most recent note on 07/02/07 notes mechanical pain in the right shoulder and thumb status post trigger finger release left side. Physical examination notes compression test positive for cervical on the right side.

Additional records have been reviewed as above. The Reviewer would note that the most recent EMG does not show evidence of C5 or 6 radiculopathy. Most recent MRI did not show any evidence of nerve root compression or foraminal narrowing. There is no documentation in the records of myotomal weakness or sensory symptoms in the C5-6 root pattern or documentation of reflex changes. Once again, referring to the guidelines, there is insufficient documentation of radiculopathy based on physical examination, imaging studies or electrodiagnostic testing at the C5-6 level. Therefore,

the right C5-6 selective nerve root block is still considered to be not medically necessary after review of the additional records.

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)