

I-Resolutions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

(512) 782-4415 (phone)

(512) 233-5110 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 26, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical ESI

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

M.D., Board Certified Orthopedic Surgeon

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

Adverse Determination Letters, 12/27/07 and 01/23/07
Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Neck and Upper Back
Office notes, 06/11/07, 06/29/07, 10/09/07, 12/17/07
Cervical spine MRI, 06/27/07
EMG/NCS study, 08/17/07 and 01/30/08
Initial physical therapy evaluation, 10/23/07
Physical therapy note, 10/26/07
Epidural steroid injection denial noted, 01/10/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was struck on the head by a falling pipe. He sustained a scalp laceration and reported the onset of neck and bilateral shoulder pain. Cervical MRI on 06/27/07 noted mild disc bulges at C 3-4, C4-5 and C5-6, with mild to moderate effacement on the ventral subarachnoid spaces. There was no significant neuroforaminal narrowing or stenosis, no focal disc extrusions, and no central canal stenosis seen. Neck pain with radiation to the right shoulder and occasional numbness in the fingertips of the right hand persisted. There was noted weakness in the right upper extremity on examination with decreased grip strength and decreased reflex in the right triceps. Cervical motion was limited with pain on right shoulder elevation and point tenderness to the posterior aspect of the neck, laterally on the right side. The impression was cervical radiculopathy. Requests for physical therapy and a cervical epidural steroid injection were not approved. Electrodiagnostic studies on 01/30/08 noted a mild chronic C5-6 nerve fiber injury at the root or plexus level on the right. Cervical epidural steroid injection at C6-7 on the right was requested again.

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

The request for an epidural steroid injection at C6-7 on the right does not appear reasonable based on the information provided.

The claimant does not have a clear radiculopathy from the C6-7 level either symptomatically or objectively by examination. Specifically, the patient does not appear to have a clear dermatomal pattern to his complaints and his MRI showed no evidence of neurocompressive pathology. The electrodiagnostic studies from 01/30/08 indicated potential mild chronic pathology at the C5-6 level without clear localization at the root or plexus level. The electrodiagnostic studies did not confirm radiculopathy from the level for which the epidural steroid request has been made.

Since symptoms, exam, and electrodiagnostic studies do not correlate with a definitive radiculopathy and the MRI does not show neurocompressive pathology, I am unable to justify the request as stated based on the information provided.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates , Neck and Upper Back

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.

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.

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)