

Notice of Independent Review Decision

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 06/03/08

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:**

Cervical epidural steroid injection number one with sedation.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.O., duly licensed in the State of Texas, Fellowship Trained in Pain Management with over twenty years of clinical experience in the active practice of Pain Management, Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain Medicine

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
718.01	62310	NA	Prosp.				Xx/xx/xx		Upheld
718.01	77003	NA	Prosp.				Xx/xx/xx		Upheld

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This claimant was injured on xx/xx/xx. She fell onto the ground, hurting her right shoulder and neck. Prior to this injury, the claimant had a two previous cervical and shoulder work injuries on Xx/xx/xx and xx/xx/xx. The claimant was seen for an Independent Medical Examination by on 11/20/07. In that review, the examiner chronicled the claimant's treatment up to that point, as well as her pain level of 8/10 and complaints of burning, aching, and pins and needle pain in the neck, right shoulder, and radial distribution of the right upper extremity. He noted that the claimant had undergone at least 28 sessions of physical therapy as of 10/17/07 with no change in pain. He also noted the claimant had undergone an MRI scan of the neck on 03/28/07, demonstrating 3-mm posterior disc bulges at C4/C5 and C6/C7 but no compression of the spinal cord or any nerve roots.

The claimant was seen by a physician for a right shoulder injection on 08/20/07, which provided no benefit. An MR arthrogram of the right shoulder was performed on 07/11/07, demonstrating a labral tear. The independent medical examiner examined the claimant, noting there were normal

reflexes in the upper and lower extremities. He noted no muscle atrophy in any extremity. There was no tenderness to palpation of the cervical spine. There was no muscle spasticity or rigidity, and reflexes were said to be 2+ bilaterally in the biceps, 1+ bilaterally and symmetric in the triceps and brachioradialis. There was said to be normal sensation in both upper extremities. The examiner felt the claimant had an uncomplicated contusion of the right shoulder as well as cervical sprain with “probably pre-existing” two level degenerative disc disease.

Electrodiagnostic studies were performed on 01/18/08. Those studies demonstrated “suggestion” of C5/C6 right radiculopathy, but no definitive evidence of such finding. On 03/28/08 the claimant was seen by a neurosurgeon. He noted her continued deep, stabbing neck pain radiating into the right upper extremity and into the first two fingers of the right hand. Physical examination documented 4/5 strength in the biceps and triceps on the right, otherwise 5/5 in all other muscles. Reflexes were said to be 1+ in the right triceps and 2+ throughout the rest of the upper extremity. Decreased sensation was noted in the C6/C7 distribution on the right. The neurosurgeon recommended CT scan myelogram and evaluation for epidural steroid injection.

Less than two weeks later, the claimant was seen for evaluation of her right shoulder. The physical examination documented normal strength and normal reflexes in both upper extremities with no deficit in either. The examiner recommended right shoulder surgery for stabilization of the glenohumeral joint. On 04/14/08 the claimant was seen for evaluation of her neck pain and numbness of the right arm. An epidural steroid injection was recommended. That request was subsequently evaluated by two separate physician advisers, both of whom recommended nonauthorization of the request. On a followup visit on 04/28/08, The physician reiterated his request for epidural steroid injection, stating the claimant had paravertebral muscle spasms from C5 through T1 and two-thirds decrease of strength in the right hand.

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

ODG Treatment Guidelines state that it is medically reasonable and necessary for epidural steroid injections to be performed when there is evidence of disc herniation causing either spinal cord compression or nerve root compromise or compression. Additionally, ODG Treatment Guidelines state that it is medically reasonable and necessary to perform epidural steroid injections when these imaging findings are accompanied by physical examination and/or electrodiagnostic study evidence of radiculopathy. In this case, there is no MRI scan evidence of disc herniation, only disc protrusion, nor is there any evidence of spinal cord or nerve root compromise or compression. The EMG studies are not definitive, only “suggestive.” Furthermore, the EMG study results do not correlate with either physical examination evidence or the claimant’s subjective pain complaints. Finally, there is clearly significant discrepancy among the various examinations documented of this claimant’s neck and upper extremities, especially in the musculoskeletal and neurologic evaluation of these areas. Therefore, absent imaging evidence of disc herniation and/or spinal cord or nerve root compression or compromise correlating with EMG study findings and physical examination evidence, the request for cervical epidural steroid injection is not medically reasonable or necessary. Therefore, I agree with the recommendation of the two independent physician advisers who recommended nonauthorization of the request, recommendations which are, therefore, upheld.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

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**INDEPENDENT REVIEW INCORPORATED**

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- 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 judgment, 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 national accepted medical literature.  
Literature and textbooks in the area of Pain Management.
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)