



## REVIEWER'S REPORT

**DATE OF REVIEW:** 04/12/09

**IRO CASE #:**

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

Cervical epidural steroid injection.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.O., duly licensed physician in the State of Texas, fellowship-trained in Pain Management, Board Certified in Anesthesiology and Certificate of Added Qualifications in Pain Medicine, over 21 years experience in the active practice of Pain Management

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. Cervical MRI scan dated 08/28/08
2. Left shoulder MRI scan dated 12/11/08
3. Thoracic MRI scan dated 12/11/08
4. Cervical myelogram/CT scan dated 12/15/08
5. Designated Doctor Evaluation by Dr. dated 12/15/08
6. Progress notes from Dr.
7. Medical records from Dr. dated 01/16/09
8. Medical records from Dr. from 02/16/09 through 03/23/09

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

This claimant was injured on xx-xx-xx while attempting to open a gait at the correctional facility where she worked. The key apparently jammed in the lock. As the claimant tried to get the key out, she felt sharp pain in her left wrist, hand, shoulder and neck. Cervical

MRI scan on 08/28/08 demonstrated “very minimal” disc degeneration at C4/C5 “without significant impingement.” Left shoulder MRI scan demonstrated mild subacromial subdeltoid bursal edema but no evidence of rotator cuff tear. Thoracic MRI scan was entirely normal.

On 12/15/08 Dr. ordered cervical myelogram/CT scan. The myelogram demonstrated a possible posterior disc protrusion at C4/C5 but no underfilling of any cervical nerve roots. The post myelogram CT scan demonstrated mild bony foraminal encroachment at C3/C4, broad-based posterior disc protrusion at C4/C5 without encroachment of the cervical cord or lateral recesses, and mild central disc bulge at C5/C6 without encroachment of the spinal cord or lateral recesses. There were “no areas of encroachment” anywhere on the CT scan.

A Designated Doctor Evaluation was performed the same day by Dr.. The claimant complained of neck, upper back, left arm, left shoulder, left wrist, and left hand pain with a sensation of paresthesia in the left hand and wrist and a pain level of 5/10. Physical examination documented that the claimant was “uncooperative throughout the entire exam” with nonspecific global tenderness over the cervical spine throughout on the left. The cervical range of motion was said to be performed “with no effort.” There was no dermatomal sensory deficit bilaterally in either of the upper extremities and normal reflexes in both upper extremities bilaterally. Grip strength was compromised by the claimant’s “poor effort.” Muscle testing was bilaterally normal throughout the neck and both upper extremities completely. Dr. stated the claimant had not reached MMI and diagnosed the claimant with cervical sprain.

On 01/16/09 the claimant was seen by Dr. who noted her ongoing pain in the left arm and numbness in the left upper arm with weakness and a pain level of 5/10. Physical examination documented the claimant to spinous process tenderness throughout the cervical spine and bilateral nonspecific tenderness throughout the cervical facet joints. The claimant allegedly had a sensory deficit in the left L5 dermatome and slight weakness of the left biceps compared to the right. Dr. performed EMG/nerve conduction studies, which demonstrated left C4/C5 radiculopathy only. He recommended transforaminal epidural steroid injections. Dr. the treating doctor, evaluated the claimant five days later, however, documenting no change in her neck pain despite three weeks of treatment, no sign improvement in her functional ability, and normal reflexes bilaterally in the upper extremities. He recommended more chiropractic treatment consisting of passive and active therapy.

Dr., a neurosurgeon, evaluated the claimant on 02/16/09, noting her continuous 5/10 level of pain in the left neck and trapezius radiating down the left arm with the claimant’s specific denial of any numbness. Physical examination documented tenderness of the cervical spine and left trapezius with localized spasm as well as tenderness over the left shoulder anteriorly and laterally. There was only slight weakness in the left triceps relative to the right and only slightly diminished left triceps reflex. Dr. started the claimant on Medrol DosePak followed by Relafen and recommended cervical epidural steroid injection (unspecified level).

Two separate physician advisers then reviewed the request, both recommending nonauthorization of the request in separate evaluations and on separate occasions.

On 03/23/09 Dr. again followed up with the claimant. He now noted her continuing pain with a pain level of 4/10 to 6/10 despite Relafen and Robaxin. Physical examination documented normal reflexes in the upper extremities bilaterally, normal sensation in the upper extremities bilaterally, and only minimal left trapezius weakness. Dr. now recommended C4/C5 discectomy and fusion and ordered a presurgical psychologic evaluation.

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

According to ODG Treatment Guidelines, epidural steroid injections are considered medically reasonable and necessary when there is evidence of disc herniation or spinal cord/nerve root compression causing radicular symptoms concordant with the MRI scan evidence and corroborated by either physical examination or EMG evidence of radiculopathy. Although Dr. report indicates that there is evidence of left C4/C5 radiculopathy, there is no radiologic imaging study evidence of a disc herniation or neural compression at the C4/C5 level, only a disc bulge. Moreover, the most recent examination by Dr. neurosurgeon, documents the claimant to have normal reflexes and sensation in both upper extremities and only very slight weakness of the left trapezius and left finger extensors relative to the right. This physical examination evidence is not consistent with, nor evidence of, radiculopathy, nor is it corroborated by either radiologic imaging study evidence or the EMG finding of left C4/C5 radiculopathy. Therefore, per ODG Treatment Guidelines, this claimant does not meet the criteria for epidural steroid injections. Therefore, the previous recommendations for nonauthorization for the requested cervical epidural steroid injection are both upheld. The requested cervical epidural steroid injection is not medically reasonable or necessary as related to the work injury of 06/10/08.

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

*(Check any of the following that were used in the course of your review.)*

- 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 national accepted medical literature (provide a description).
- \_\_\_\_\_ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)