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Notice of Independent Review Decision

DATE OF REVIEW: January 29, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical ESI #1, level not indicated, to include fluoroscopy, epidurogram, and anesthesia

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

The physician providing this review is a Doctor of Medicine (M.D.). The reviewer is national board certified in Physical Medicine and Rehabilitation as well as Pain Medicine. The reviewer is a member of International Spinal Intervention Society and American Medical Association. The reviewer has been in active practice for ten years.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Diagnostics (05/11/05 - 01/28/08)
Operative note (03/22/06)
Office notes (04/30/07 - 11/07/08)

Diagnostics (09/14/07 - 01/28/08)
Office notes (11/05/08 – 11/27/08)
Operative note (11/08/06)
Utilization reviews (11/11/08 – 12/04/08)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old female who sustained an industrial injury. The exact mechanism of injury is not available.

In May 2005, magnetic resonance imaging (MRI) of the right shoulder revealed small mildly retracted distal anterior supraspinatus tear and mild acromioclavicular (AC) joint hypertrophy.

On March 22, 2006, , M.D., performed right shoulder glenohumeral arthroscopy with debridement of labrum and rotator cuff followed by open rotator cuff repair with an acromioplasty and open distal clavicle resection.

, M.D., evaluated the patient for right-sided chest and sternum pain. *He noted the patient had a stimulator placed for reflex sympathetic dystrophy (RSD) of the left knee by Dr . The patient had a revision of the stimulator done in May 2006 and recently had a revision of the left knee replacement in November 2006.* Examination revealed tenderness of the right under breast area from sternum to the spine and slight dyspnea on exertion related to pain with respiration. He assessed intercostal neuritis and RSD of the left knee and referred the patient to Dr. for an intercostal block.

In April 2007, Dr. continued home exercise program (HEP) and aquatic therapy for the right shoulder pain. In June 2007, he administered a Marcaine and steroid injection to the subacromial space of the right shoulder. Electromyography/nerve conduction velocity (EMG/NCV) of the right upper extremity revealed carpal tunnel syndrome (CTS) of a mild degree. The patient continued to have numbness into the thumb, index, and middle finger as well as pain in the proximal shoulder and posterior neck.

A computerized tomography (CT) scan of the cervical spine was obtained in January 2008, revealing: (1) A 1-mm disc osteophyte complex at C5-C6 slightly flattening the thecal sac, uncinete joint spurring, and facet joint hypertrophy causing mild bilateral foraminal stenosis. (2) A 2-mm disc osteophyte complex at C6-C7 reducing the AP diameter of the central canal causing mild central stenosis; and uncinete joint spurring and facet joint hypertrophy causing mild bilateral foraminal stenosis.

In August 2008, Dr. referred the patient to Dr for pain management.

In November, the patient was evaluated at for severe constant neck pain. Examination revealed antalgic gait, decreased deep tendon reflexes in the upper extremities (right more than left), atrophy of the trapezius muscle, and pain over the C6-C7 vertebra. The physician diagnosed cervical syndrome, C5 to C7 bilateral foraminal stenosis, and C6-C7 central canal stenosis and recommended a cervical epidural steroid injection (ESI) and follow-up on a p.r.n. basis.

On November 11, 2008, , M.D., denied the request for cervical ESI #1, level not indicated to include fluoroscopy, epidurogram, and anesthesia with the following rationale: *"This xx-year-old female sustained an industrial injury on xx/xx/xx. The initial mechanism of injury was not documented for review. The current diagnosis is cervical radicular pain with foraminal stenosis. The patient has current complaints of neck pain and left upper extremity pain. An examination on November 5, 2008, showed decreased bilateral upper extremity DTRs, right*

greater than left, with trapezius muscle atrophy. An MRI on January 28, 2008, showed a 1-mm disc-osteophyte complex at the C5-C6 level and a 2-mm disc-osteophyte complex at the C6-C7 level with mild bilateral foraminal stenosis at each level. There were no sensory or motor deficits noted. Attempts at case discussion were unsuccessful. In this case, there was no documentation of radiculopathy. There were minimal findings on the examination and MRI of the cervical spine. Therefore, the diagnosis of radiculopathy was not confirmed, and thus, the ODG would not support a cervical ESI at this time. Thus, the recommendation is for non-certification of this request.”

On December 4, 2008, , M.D., denied the appeal for cervical ESI #1 to include fluoroscopy, epidurogram, and anesthesia with the following rationale: *“This xx-year-old female had a history of neck pain since January 4, 2005. The mechanism was not provided for review. She had a diagnosis of chronic neck pain. According to a medical note on November 27, 2008, the neck pain had radiated into the left arm. The pain was constant. On physical examination, there was tenderness in the paracervical region with spasms. An MRI from January 28, 2008, showed 1 mm disc osteophyte at C5-C6 and 2-mm at C6-C7. An electromyogram (EMG) showed right CTS. The Official Disability Guidelines (ODG) state, “Criteria for the use of ESI: (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) Injection should be performed using fluoroscopy (live x-rays) 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. This patient does not meet the above criteria for any ESI and should be denied as there is no documented radiculopathy or conservative treatment that failed.”*

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

The patient has clear signs of radicular symptomatic pain and radiculopathy on exam noted by both the attending physician and the reviewing physicians. Per ODG a single ESI is warranted and supported for findings noted.

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

- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES (ODG)**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**