

Notice of Independent Review Decision

DATE OF REVIEW: 12/02/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left C6/7 Transforaminal Epidural Steroid Injections with cath

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

The physician providing this review is Board Certified, American Board of PM/Occupational Medicine and Board Certified, American Board of Emergency Medicine. This reviewer's primary practice is in the area of occupational environmental medicine. She has hospital privileges in the state of Texas.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The history and documentation do not objectively support the medical necessity of ESIs to the cervical spine done on 10/16/10 and again on 10/29/10.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records received: 15 page fax on 11/12/10 Texas Department of Insurance IRO request and 19 page fax on 11/16/10 URA response to disputed services including administrative and medical records.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant, a male, is being treated for an injury that occurred on xx/xx/xx when he struck his helmeted head on a stationary object. Dr. ordered an MRI on 09/01/10. He injured his neck and on 10/06/10, he saw Dr. having been referred by Dr.. He complained of low neck, left shoulder, and scapular area pain with left upper extremity pain. He also had headaches. His pain radiated down his left arm to his ulnar forearm and 2nd and 4th fingers. He complained of squeezing, tension-type throbbing pain with stabbing, knife-like shooting pains worse with almost all movements and activities. It was relieved with his medications and PT gave him some relief of his shoulder pain but not his upper extremity or headache pain. He was using TENS and got some relief from his headache. He also had numbness and tingling into his hand. He had rare symptoms in the RUE. He had significant weakness of the LUE. He was using Zanaflex and Norco.

An MRI of the cervical spine dated 09/03/10 showed a C6-7 2-mm disc protrusion with no canal or foraminal encroachment. There was a 1 mm disc bulge at C3-4 and at C5-6 with no canal or foraminal encroachment. EMG/NCV was scheduled for the next day. He was using the TENS on his left trapezius area that day. His pain was 8/10 level. He had positive Spurling's on the left side (not described). Spurling on the right side caused left sided neck pain. He had significant tenderness of the left posterior cervical paraspinals into the left trapezius and periscapular region and into the rhomboid muscles with no trigger points. He had minimal tenderness into the right mid trapezius and limited ROM due to pain with neck extension causing significantly increased pain. Neck flexion caused mild to moderate discomfort. Motor strength was 5/5 on the right and 4+/5 on the left upper extremity. He had decreased sharp/dull discrimination in the left C7 dermatomal distribution and it was otherwise intact. DTRs were intact.

Assessment: cervical radiculitis, cervical disc protrusion with probable chemical radicular irritation from a possible annular tear not identified on the MRI. He saw Dr. on an unknown date and was status post two PT sessions. He reported some improvement. He also reported abdominal pain. He had increased pain left C6 and C7 with intact reflexes and FROM of all joints. He was taking ibuprofen, Misoprostol, and hydrocodone/acetaminophen. He was diagnosed with neuralgia/neuritis. ESIs were recommended (left C6-7 transforaminal). EMG was done on 10/08/10 and there was no report of radiculopathy.

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

The history and documentation do not objectively support the medical necessity of ESIs to the cervical spine that were done on 10/16/10 and again on 10/29/10. There is no clear evidence of radiculopathy on physical examination or on electrodiagnostic studies that is consistent with the findings on the MRI. ESIs are not supported for the treatment of radiculitis. There is no documentation of significant and sustained benefit from the initial ESI that warranted repeating the injection less than two weeks later. There is no indication that the claimant completed or attempted and failed a reasonable course of conservative treatment and there was mention of improvement with medication/PT/TENS. The medical necessity of these injections has not been clearly demonstrated and is not supported by the ODG recommendations.

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)**

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