

SENT VIA EMAIL OR FAX ON
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/10/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Epidural Steroid Injection

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

Reviewer is Board Certified in Family Practice with a Certificate of Added Qualification in Sports Medicine

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

OD Guidelines

Denial Letters 3/19/10 and 3/31/10

Institute 12/22/09 thru 3/12/10

Dr. I 3/13/06 thru 6/16/08

MRIs 6/6/08, 6/3/08, 11/18/09

Health 1/22/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male who was injured in xxxx while working. There is not a note for the original injury—the clinical notes indicate the patient said that it occurred when he was pulling up under the xxxx and sustained neck and shoulder pain

The patient's recent clinical visits restarted in March of 2006. Dr. indicates the patient's last visit prior to this was in 2002. There are no notes documenting the patient's condition or

injuries at the time of the initial incident

On the visit in March of 2006, the visit appears to be a progress check; at that time the patient reports chronic neck pain ongoing since the time of his original xxxx injury. In March of 2008, the patient returns complaining of increased neck pain and a vague lateral shoulder pain. He is given NSAID's and returns 2 months later, now with increased lateral shoulder pain, less neck pain and "left ulnar hand numbness". At this time, he is diagnosed with rotator cuff tendonitis and a cervical MRI is ordered to rule out neck pathology referring the pain

The cervical MRI is done on 6/3/08 that shows multilevel degenerative joint disease, multilevel foraminal stenosis and facet arthropathy (with minimal changes at C7-T1. Some mild spinal stenosis was seen at C6-7. Upon follow up in June 2008, the patient's symptoms were the same with the addition of left arm weakness. There is no physical exam documented for this visit but the MD felt that the patient's symptoms were not explained by the cervical MRI and a shoulder MRI was ordered. The shoulder MRI was performed on 6/6/08 and the patient was found to have a full thickness supraspinatus tear. Surgical repair of the rotator cuff was completed in December 2009. Two weeks after his left rotator cuff surgery, the patient is seen by Dr. for his neck pain. At that time, a physical exam indicates weakness in the left arm but due to the patient being post op, it is not clear at that time whether this is due to his post op condition or whether there will be persistent weakness in any muscle groups when his injury has been rehabilitated. There were noted reflex changes but no sensory changes at that time. At that time, Dr. did not feel the patient's pain was radicular and felt the neck pain may be facet related. He proceeded with facet injections on January 22. The patient had no immediate relief from the anesthetic so it was felt the facet was not the source of the pain. He did, however, report some overall neck pain improvement. The patient was seen on 1/29/10 and 3/12/10 by Dr. for follow up. At these visits, Dr. offered the options of medication, epidural injection or surgery for the patient's neck pain. There is no documentation after the December visit of the patient's physical findings; therefore, it is unclear whether there were any continued radicular findings. Also of note is that there is no mention of whether the patient ever had Physical therapy for his neck and whether it helped or he completed a complete course.

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

It is the IRO reviewer's duty to determine whether the indicated procedure is medically necessary in this case. It is not our position to determine whether the procedure is covered under the patient's insurance/whether it is compensable.

In examining this case, the patient had an injury in xxxx to which he attributes his current neck, shoulder and arm symptoms. The MRI of the shoulder showed a large rotator cuff tear, which was appropriately repaired by surgery. If the tear occurred as far back as xxxx, one might expect improvement of the symptoms but not full recovery with respect to strength of the rotator cuff muscles. After repair of the rotator cuff, the patient reportedly went through PT for his shoulder but we do not have a PT or MD report indicating his level of function relative to the rotator cuff and opinion on what symptoms may be rotator cuff or shoulder related that may or may not improve with time. Although the procedure in question is one for treatment of his neck, one must review and take the shoulder injury and treatment into consideration as the symptoms may overlap.

In looking at the patient's neck pain, the MRI indicates multilevel degenerative disc disease, facet hypertrophy and foraminal stenosis. There are no notes provided indicating that the patient had any other diagnostic tests such as an EMG to look at the neck as the source of arm symptoms. There are no notes provided to indicate the patient had physical therapy for his neck pain. If he did have neck PT, there is no note of response to and extent of the therapy. Early notes by Dr. indicate that the patient had no radicular signs on exam. There is one note that documents some possible radicular exam signs in December 2009 but this is 2 weeks post op and a follow up exam is not documented on any of the visits by Dr. to indicate

this is a persistent finding.

The ODG guidelines outline the indications for epidural steroid injection. The first two criteria for a therapeutic epidural steroid injection are: 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)

The patient has not met these criteria and thus a therapeutic epidural steroid injection is not medically indicated at this time.

Clinical notes indicate the epidural steroid injection is being requested for therapeutic not diagnostic reasons. There are separate criteria for diagnostic epidural steroid injection of the cervical spine. The first section of that criteria is as follows: Criteria for the use of Epidural steroid injections, diagnostic

To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below

(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies

(2) To help to determine pain generators when there is evidence of multi-level nerve root compression

(3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution) but imaging studies are inconclusive

Again, the patient's case does not meet these criteria as the radicular pain and physical findings are not adequately defined or documented in the clinical notes. Also, without EMG studies or failed physical therapy, the diagnostic imaging is not necessarily ambiguous.

In conclusion, for the aforementioned reasons, the prior judgment is upheld and epidural steroid injection is not found to be medically necessary at this time.

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

ACOEM-AMERICA 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)