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Notice of Independent Review Decision

DATE OF REVIEW: JULY 14, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical epidural pain block at C5-C6-C7

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

Diplomat, American Board of Orthopaedic Surgery
Fellowship trained in spine surgery

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, the patient strained his back and neck while employed at xx. He was working on the tractor and an employee hit him from behind.

The patient saw, M.D., who did x-rays and prescribed oral pain medications.

Magnetic resonance imaging (MRI) of the cervical spine was obtained. This revealed straightening of the cervical lordosis with muscle spasm on strain, posterior 2-mm marrow signal irregularity along the mid to lower cervical spine, posterior 1 to 2 mm disc protrusion pressing on the thecal sac at C4-C5, posterior 2 mm disc protrusion/herniation with minimal marginal spondylosis pressing on the thecal sac narrowing the medial aspect of the neural foramen bilaterally at C5-C6 and C6-C7, mild hypertrophy of the apophyseal joints at both the C5-C6 and C6-C7 levels.

MRI of the lumbar spine revealed: (1) At L2-L3 and L3-L4, posterior 1- 2 mm disc protrusion/herniation pressing on the thecal sac. (2) At L4-L5, posterior 3-4 mm disc protrusion/herniation and lateral facet hypertrophy narrowing the lateral recess on each side with no spinal stenosis. (3) At L5-S1, posterior 3-4 mm disc protrusion and moderate bilateral facet hypertrophy. (4) There was focal low signal intensity of 7 mm diameter structure in the central aspect of the L3 vertebral body of uncertain etiology.

In October, the patient was seen at Practice Associates for complaints of continued low back and neck pain. He had completed his PT and had not been working. Examination revealed paraspinal tenderness in this cervical and lumbar spine. The patient was diagnosed with cervical and lumbar sprain/strain and ordered electromyography and referred for pain management.

M.D., saw the patient for pain to the lower back and neck which was stabbing and dull in nature with radiation to the upper back and shoulder blades. He also complained of dull throbbing low back pain. Examination revealed moderate tenderness to the cervical paraspinals and facets at C3-C4, C4-C5, C5-C6, C6-C7 and C7-T1 with myofascial strain to the cervical paraspinal, bilateral upper trapezius, bilateral anticus and bilateral supraspinatus. Cervical range of motion (ROM) was restricted in all directions and Spurling's test positive lateralizing to the right side and midline. The grip strength was 4/5 bilaterally and Tinel's was positive on the right. Dr. diagnosed neck pain with cervical facet syndrome, neck pain with myofascial, trigger point to bilateral cervical paraspinals, upper trapezius and bilateral anticus. He planned bilateral cervical facet block at C5-C6 and C6-C7 and suggested considering myofascial trigger point injection (TPI) if the cervical facet block did not relieve his pain. He also prescribed heating pad and Norco and diclofenac.

Designated doctor M.D., noted that the patient was treated conservatively with PT for two-and-a-half months which did not help, transcutaneous electrical nerve stimulation (TENS) unit and two shot of injections which did not help either. On examination of the right shoulder, there was tenderness over the trapezius. Dr. assessed degenerative disc disease (DDD) of the lumbar from L2-S1 (resolved),

DDD of the cervical from C5-C7 (not treated); and cervical radiculopathy, right upper extremity. He opined the patient had not yet reached MMI as a cervical program was still to be assessed.

2011: As the patient continued to have pain to the neck and lower lumbar spine, Dr. referred him to a neurosurgeon and continued diclofenac, hydrocodone and Amrix.

M.D., neurosurgeon, noted complaints of constant pain in his back and neck, which was very tender and straight leg raise (SLR) to 60 degrees bilaterally. He assessed lumbar radiculopathy; added diclofenac and recommended obtaining films to better evaluate the patient's symptoms. On follow-up, the patient complained that he could not sleep. Dr. assessed cervical and lumbar radiculopathy and recommended cervical epidural pain block at C5, C6 to C7.

On June 3, 2011, the request for ESI was not certified with the following rationale: *"In the medical report dated May 27, 2011, the patient presents with neck pain, more to the left side, with bilateral arm pain, tingling and numbness. On physical examination, he has constant pain on his left arm and numbness with no relief. The proposed service is indicated in the presence of radiculopathy as corroborated by electrodiagnostic and/or imaging studies aside from the positive examination findings. There is none in the records that supports this. There is no documentation provided with regard to the failure of the patient to respond to conservative measures such as evidence-based exercise program and medications prior to the proposed injections. With these, the medical necessity of the request is not substantiated and hence not certified."*

Dr. recommended continuing the current medications including Robaxin and tramadol and also gave the patient prescription for lumbar back brace.

On June 29, 2011, the appeal was not certified with the following rationale: *"Records indicates that there was an adverse determination of the previous review. In a acknowledgment of the previous non-certification to the lack of documentation and electrodiagnostic and/or imaging studies, and no failure of the patient to respond to conservative measures such as evidence-based exercise program and medications prior to the proposed injections, there is now documentation, per May 27, 2011 medical report, the patient presenting with neck pain, bilateral arm pain, tingling and numbness of the arm. Physical examination revealed neurologically the patient has constant pain in the left arm and numbness with no relief. Cervical spine MRI dated August 19, 2010, revealed strengthening of the lordosis, marrow signal irregularity along the mid to lower cervical spine, disc pathology seen at the C4-C5, C5-C6 and C6-C7 levels; C5-C6, a 2-mm disc protrusion/herniation with minimal margin of the spondylosis pressing on the thecal sac narrowing the medial aspect of the neural foramen bilaterally.; at C6-C7, a 2-mm disc protrusion/herniation with minimal margins of spondylosis pressing on the thecal sac narrowing the medical aspect of the neural foramen bilaterally. EMG/NCV of the upper extremities dated September 22, 2010, revealed a normal study (per medical report date February 8, 2011 signed by Dr.). Conservative treatment has included ROM exercises, PT,*

medications, and a TENS unit. However, there is no documentation of radiculopathy (pain, numbness, and/or paresthesias in a dermatomal distribution; and associated clinical findings such as loss of relevant reflexes, muscle weakness and/or atrophy of appropriate muscle group, loss of sensation in the corresponding dermatomes.). Therefore the medical necessity of the requested has not been substantiated."

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

I have had the opportunity to review multiple forwarded records. These included the imaging study of the cervical spine which was completed on August 19, 2010. This was performed at the Open MRI. The study was interpreted by Dr. (M.D.). This MRI showed multiple levels of small disc abnormality listed as 1 to 2 mm disc bulge protrusion at C4-C5 without neuroforaminal narrowing, also C5-C6 2 mm disc protrusion/herniation with minimal marginal spondylosis presses on the thecal sac narrowing the medial aspect of the neuroforamen bilaterally and at C6-C7 posterior 2 mm disc protrusion/herniation with minimal marginal spondylosis presses on the thecal sac narrowing the medial aspect of the neuroforamen bilaterally. At C7-T1, there was no disc bulge, herniation, or neuroforaminal narrowing.

The patient also had MRI of the lumbar spine completed at the same facility which is not a subject of today's review.

On October 8, 2010, the patient had evaluation by Practice Associates and was noted to have a diagnosis of cervical sprain/strain and lumbar strain. The patient was subsequently seen by Dr. and diagnosed with cervical facet syndrome with trigger point myofascial disorder and the paracervical musculature. He proposed cervical facet blocks at C5-C6 and C6-C7 as well as trigger point injections. Please note that he did not report any discrete neurological deficits. He noted tenderness in the paracervical muscles and facets at C3-C4, C4-C5, C5-C6, and C6-C7.

The patient then had the designated doctor exam with Dr. (M.D.) on February 8, 2011. Dr. noted the treatment history of two-and-a-half months of physical therapy as well as a trial of TENS unit which did not help as well as injections which also did not help. The EMG nerve conduction of the upper extremities was considered normal without cervical radiculopathy as of September 22, 2010. Dr. reported that there was a decreased right triceps reflex as well as decreased strength of 4/5 on the right triceps. No atrophy however was reported.

The patient was not placed at maximum medical improvement. The patient was then referred to two different neurosurgeons and the patient was not subsequently seen by them despite the referral by Dr. (M.D.). Dr. then referred the patient to Dr. (M.D.). Dr. examination does not describe a specific dermatomal deficit. He noted that the patient was complaining of constant pain in the back and leg. He stated that the patient needed better films. There was a

report of some right hand numbness but again nothing dermatomally was validated.

On May 13, 2011, Dr. again evaluated the patient. At that point, he stated that the patient had tenderness to the cervical spine and lumbar spine on exam. The neck pain was increased and the radicular pain was with no improvement. However again, there is no specific neurological deficit dermatomally described. He proposed a C5-C6-C7 epidural pain block at Surgical Center.

The subsequent evaluation of May 27, 2011, by Dr. proposed the same treatment regimen. There were utilization review denials forwarded as well for review. On June 10, 2011, a low back brace was proposed by Dr. which was also recommended in his June 10, 2011, office visit.

Thus the records for review including the MRI report of the cervical spine do not validate that there is any specific nerve root entrapment at C6-C7 or C5 or C6 that would warrant cervical epidural steroid injections. The EMG nerve conduction was referenced as being normal, i.e., no evidence for a cervical radiculopathy. Given this lack of objective dermatomal deficit, the proposed cervical epidural steroid injections are not consistent with the ODG which requires objective radiculopathy to be present for the use of the cervical epidural steroid injection. Moreover the request is for three levels and we have no validation that this is present. Thus the request is not considered a medical necessity as per ODG criteria.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**