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Notice of Independent Review Decision

DATE OF REVIEW: 7-1-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of epidural steroid injection at C6-7 with fluoroscopy and possible anesthesia.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the medical necessity of epidural steroid injection at C6-7 with fluoroscopy and possible anesthesia.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

Medical records indicate that this worker was injured while working as a on She reported that she struck her head against a. There was loss of consciousness. An MRI of the cervical spine dated xx/xx/xx indicated that there was moderate left foraminal stenosis at the C3-4 level and mild, 1 millimeter disk bulges at C5-6 and C6-7 without evidence of canal or foraminal stenosis. EMG and nerve conduction studies performed on February 11, 2010 were said to be consistent with “modest bilateral chronic C6 radiculopathy.” There was no description of membrane instability or motor unit change. The only statement of abnormality in the report was that there was “moderately reduced motor unit action potentials” in the left deltoid and in the pronator teres muscles bilaterally.

On June 23, 2010, the injured worker began treatment with, M.D. Dr. noted the patient’s injury and stated that she previously had two epidural steroid injections in February, 2010. Later, in a note dated August 4, 2010, Dr. stated that the injections she had received were facet injections. Dr. noted a past history of bipolar disorder. Physical examination on June 23, 2010, indicated that there was a moderate restriction of motion in the cervical spine in all planes, diffuse posterior cervical tenderness, no spasms, 2+ and symmetrical deep tendon reflexes, 5/5 strength in the upper extremities, and nondermatomal sensory deficits in the upper extremities. Dr. gave an opinion that the injured worker was an excellent candidate for functional restoration and the injured worker subsequently entered a functional restoration program at Pride. During her treatment at Pride, Dr. recommended epidural steroid injections, but these were denied. Multiple trigger point injections were performed.

The injured worker completed her functional restoration program and was evaluated by Dr. on September 22. At that time, her pain was rated as 2/10. She had normal cervical spine range of motion and only a mild deficit in cervical spine strength. It was determined that she was capable of functioning at a heavy PDL. She was returned to full duty on October 4, 2010.

Dr. continued to follow the injured worker. On December 22 2010, Dr. recommended a short course of myofascial release physical therapy for cervical and periscapular myofascial pain. This course of physical therapy was denied.

On March 18, 2011, Dr. stated that the injured worker was complaining of headaches and tremors in the hands. He stated that she was questioning the possibility of injection management. He documented moderately restricted cervical range of motion, tenderness in the levator scapulae muscles, symmetrical deep tendon reflexes, 5/5 upper extremity strength, and a sensory decrease in the left C6 distribution. He diagnosed a cervical radiculopathy with progressive radicular symptoms as well as cervical myofascial pain. He recommended trigger point injections and a trial of epidural steroid injections.

On April 1, 2011, an epidural steroid injection was performed. A follow-up note from Dr. dated April 13 indicated that the injured worker had continued posterior neck pain

and headaches with intermittent facial numbness. He stated that there was no complication from the injection. He stated that she felt "somewhat better" but was still not at a level that she thought she would be an asset in the work place. Dr. documented moderate restriction of cervical range of motion, 2+ deep tendon reflexes, 5/5 strength, and a sensory decrease in the left C6 dermatome. He recommended a repeat cervical epidural steroid injection due to partial improvement, lack of complications, and the risk of needle misplacement due to an inability to use dye.

An Amended Assessment dated April 19, 2011 and signed by, R.N., FNP, and Dr. indicated that the injured worker was in "quite a bit of pain in the neck and mid back area." The note further states that the injured worker "had injections and found these were not very helpful." There are records of two denials of repeat epidural steroid injections as well as reconsideration letters from Dr. and an evaluation from him dated May 20, 2011. In that note, Dr. documented moderate restriction of cervical range of motion, no spasms, 2+ and symmetrical deep tendon reflexes, 4/5 strength in the left wrist extensors, and sensation well preserved.

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

Recommend denial of requested service. This worker was injured in a work related accident on xx/xx/xx. She received physical therapy, two facet joint injections, one epidural steroid injection, multiple trigger point injections, and multiple medications. She continues to complain of discomfort.

According to Dr. notes, the injections that the injured worker received early in the course of her treatment were facet injections. This is documented in Dr. note of August 4, 2010. The epidural steroid injection performed on April 1, 2011 did not provide much in the way of relief, according to notes from the treating physician and R.N., FNP. There is no quantification of the improvement she did receive and no description of length of time that any improvement lasted.

In order for an individual to receive epidural steroid injections, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The records reviewed do not clearly document the presence of radiculopathy. In the records provided, deep tendon reflexes were consistently described as 2+ and symmetrical. There are descriptions of subjective sensory decrease in the left C6 distribution, but the most recent evaluation indicated that sensation was well preserved. In the entire medical record reviewed, the only description of any weakness was the note of Dr. dated May 20, 2011 when strength in the left wrist extensors was said to be 4/5. Otherwise, strength was consistently documented as being normal.

According to ODG Treatment Guidelines, electrodiagnostic studies are only moderately sensitive, 50% to 71%, for diagnosis of radiculopathy. A diagnosis of radiculopathy requires identification of neurogenic abnormalities in two or more muscles that share

the same nerve root enervation but differ in their peripheral nerve supply. The only “neuropathic” abnormality described in the EMG report was “moderately reduced motor unit action potentials” in the left deltoid and in the pronator teres muscles bilaterally. It is unclear as to exactly what the electromyographer meant by this. It is unclear as to whether he was describing an actual decrease in recruitment of motor units or a lack of voluntary effort. There is no description of membrane instability such as fibrillation potentials or positive sharp waves and no description of changes in the configuration of the motor unit action potentials. The “reduced motor unit action potentials” is, at best, a “soft” indication of neuropathic changes which would remotely describe a radiculopathy. A radiculopathy is not confirmed consistently in the medical record by physical examination. Imaging studies show no evidence of foraminal or nerve root compromise at the C6 level.

There is no clear description in the medical record of benefit from epidural steroid injection that was performed on April 1. There is no description of the level of pain relief or the duration of pain relief. In fact, statements signed by Dr. dated April 19, indicate that the injured worker “had injections and found these not very helpful.” A second block is not recommended by the ODG Treatment Guidelines if there is inadequate response to the first injection. In the therapeutic phase, “repeat blocks should be offered only if there is at least 50% pain relief for six to eight weeks.” This injured worker does not meet ODG Treatment Guidelines for medical necessity for a cervical epidural steroid injection at C6-7 with fluoroscopy and possible anesthesia.

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)**