

# MATUTECH, INC.

PO BOX 310069  
NEW BRAUNFELS, TX 78131  
PHONE: 800-929-9078  
FAX: 800-570-9544

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## Notice of Independent Review Decision

**DATE OF REVIEW:** April 28, 2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Cervical epidural steroid injection C2-C3, PT post injection (62310, 77003, 72275, 62264)

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

Certified, American Board of Orthopaedic 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):**

This is a xx who sustained injury on xx/xx/xx, while disassembling a scaffold approximately 100 feet high when he felt a sharp pain in his low back and right groin area.

The next day, the patient was seen by a company doctor who obtained x-rays and diagnosed low back sprain/strain and an inguinal hernia and released the patient back to light duty work.

M.D., noted reducible right inguinoscrotal hernia. On August 2, 2010, he performed repair of hernia with Prolene hernia system.

D.C., evaluated him for persistent pain in the entire spine with low back pain radiating to the right buttock. Examination showed 4/5 motor strength in the cervical and lumbar flexors and extensors with pain; restricted cervical and lumbar ROM with localized soft tissue pain; hypertonicity of the left trapezius and cervical paraspinal musculature; positive cervical compression, cervical distraction and shoulder depression tests; spasticity over the lumbar paraspinal musculature bilaterally and positive SLR, Kemp's and Yeoman's bilaterally. Dr. assessed lumbar radiculitis, sprain/strain to the cervical, thoracic and lumbar spine and muscle spasms and recommended 12 sessions of active rehabilitation.

Dr. from Anesthesia Back Pain Center assessed lumbar strain, lumbar radiculopathy, lumbar disc syndrome, lumbar facet joint neuritis and bilateral SI joint neuritis and treated the patient with Lortab, Soma, Elavil and Valium. He recommended MRIs of the lumbar and cervical spine and an electrodiagnostic study.

In December 2010, MRI of the cervical spine revealed: A 2-mm right paracentral disc protrusion at C3-C4 with minimal right paracentral annular fissuring and a 1-mm posterior central disc protrusion at C5-C6. There was marked enlargement of the palatine tonsils bilaterally with high-grade oropharyngeal airway narrowing, shotty posterior triangle and internal jugular chain lymph nodes, with at least one enlarged jugulodigastric node on the right measuring 1.8 cm. Moderate to marked chronic paranasal sinus disease.

MRI of the lumbar spine revealed the following: A 6-mm left paracentral and foraminal disc protrusion at L4-L5 with mild left paracentral inferior extrusion extending behind the upper one quarter of L5. Mild left lateral recess stenosis with mass effect upon the proximal left S1 root. Moderate left foraminal encroachment with flattening of the exiting left L5 root.

On February 15, 2011, M.D., an orthopedic surgeon, evaluated the patient for low back pain which he rated as 6/10 radiating to both lower extremities associated with numbness and tingling and neck pain rated as 4/10 radiating into the bilateral upper extremities with numbness and tingling. On examination, Dr.

noted severe tenderness in the mid to lower lumbar region, more on the left; decreased lumbar ROM; positive SLR on the left; weak motor strength in the left lower extremity and paresthesias along the lateral aspect of leg down into the side of left foot. Examination of the cervical spine revealed tenderness in the posterior region, decreased ROM, positive axial compression and Spurling's tests and mild paresthesias in the hands bilaterally. He obtained x-rays of the cervical and lumbar spine and noted normal findings. He reviewed MRI of the lumbar spine and noted a sizeable disc herniation at L4-L5 with compression on the left side while on MRI of the cervical spine he noted disc protrusion at the C2-C3 level. Dr. assessed herniated nucleus pulposus at the L4-L5 with left-sided radiculopathy and disc protrusion at the C2-C3 level. In view of exhausted treatment with medications and PT and MRI findings, he recommended lumbar and cervical ESIs with post injection PT and continued oral anti-inflammatories as prescribed.

On March 4, 2011, in an initial utilization review, the request for cervical ESI C2-C3, PT post injection (62310, 77003, 72275, 62264) was denied with the following rationale: *"The history and documentation do not objectively support the request for an ESI or PT at this time. There is no documentation of radiculopathy on PE or by EMG that is consistent with the imaging study that showed no nerve root compression. His complaints are worse on the **left** side but the MRI showed findings on the **right** side. This inconsistency has not been explained. The claimant has exhausted PT previously and would not be expected to receive significant or sustained benefit from another course at this time. The medical necessity of these requests has not been clearly demonstrated. I was unable to contact Dr. for clarification."*

On March 21, 2011, per utilization review, an appeal/reconsideration for cervical ESI C2-C3, PT post injection (62310, 77003, 72275, 62264) was denied with the following rationale: *"There was no peer discussion with treating physician. The ODG recommend epidural steroid injections for individuals where radiculopathy is documented on clinical examination, corroborated by imaging studies and/or electrodiagnostic studies and for whom conservative measures have failed. In this case, it is clearly documented that conservative treatment has failed. In the form of physical therapy and medical management but they do not make a convincing case of neurocompressive lesion and/or clinical findings that would be consistent with radiculopathy. In particular the MRI scan does not describe significant neurocompression and other than bilateral paresthesias to the upper extremities which would be nonspecific and not consistent with the reported level of concern in the cervical spine. There is no clear evidence of radiculopathy; thus based on the information provided, the request cannot be viewed as reasonable and medically necessary. Recommend previous determination be upheld."*

On March 25, 2011, Dr. performed lumbar ESI and lysis of adhesions.

On April 7, 2011, Dr. noted the lumbar ESI gave temporary relief and the pain slowly returned. The patient presented with low back pain which he rated as 5/10 that radiated into the bilateral lower extremities, left greater than right. He also complained of neck pain rated as 6/10 with pain occasionally radiating to the bilateral upper extremities. Lumbar examination remained unchanged. Examination of the cervical spine revealed tenderness in the posterior cervical

region with decreased ROM and positive axial compression test. The patient had mild paresthesias in his hands bilaterally. Dr. recommended post injection PT for the lumbar spine and follow-up in a few weeks to monitor the progress. For the cervical spine, decision for cervical ESI was still awaited. Medications as prescribed were continued.

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

Upon review of the medical documentation, there is insufficient objective evidence of an acute, focal pathoanatomic lesion that may be directly attributed to the MOI, the initial presenting subjective symptoms, the interval history, or pertinent positive physical exam findings (or lack thereof). The documentation is less-than-compelling for cervical radiculopathy related to any particular nerve root level or corresponding neurocompressive lesion, which has been discussed by the reviewing physicians. ODG publishes specific criteria for the determination of clinical radiculopathy, and the necessity for ESIs is predicated on the clinical evidence of nerve-root-specific clinical radiculopathy. The denial for cervical ESIs appears to be supported.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**