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Notice of Independent Review Decision

DATE OF REVIEW: 11/08/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute:

CPT:	Description:	Request Date:	Determ Date:	Status
62310	Injection, w/wo contrast; diagnostic/therapeuti	09/29/11	10/11/11	Non-Authorized
77003	FLUOR GID&LOCLZI NDL/CATH SPI DX	09/29/11	10/11/11	Non-Authorized
72275	Epidurogram	09/29/11	10/11/11	Non-Authorized
52264	Eidural lysis of adhesions	09/29/11	10/11/11	Non-Authorized

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

Texas Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Cover sheet and working documents
2. Designated doctor examination dated 12/21/09, 09/17/10, 06/25/11
3. Peer review dated 08/24/10, 04/19/11, 10/18/11
4. Impairment rating evaluation dated 08/26/11
5. Notification of suspension of indemnity benefit payment dated 12/28/09
6. Notification of MMI/first impairment income benefit payment dated 12/28/09
7. Follow up office visit dated 03/10/11
8. Radiographic report dated 05/04/11
9. MRI left shoulder dated 08/17/09
10. MRI cervical spine dated 08/17/09
11. MRI lumbar spine dated 08/17/09
12. Orthopedic consult dated 04/07/11, 05/10/11, 06/07/11, 07/26/11, 09/09/11, 09/26/11

13. Adverse determination letter dated 10/11/11, 09/19/11
14. Discharge summary dated 07/21/11
15. Letter dated 08/04/11
16. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male whose date of injury is xx/xx/xxxx.

An MRI of the lumbar spine dated 08/17/09 revealed mild bilateral foraminal stenosis at L2-L3; mild central canal stenosis at L3-L4 with mild right and moderate left foraminal stenosis and exiting root impingement. At L4-L5, there was moderate multifactorial central canal stenosis and intradural root compression; mild right and moderate left foraminal stenosis and exiting L4 root impingement. At L5-S1, there was moderate to severe right and moderate left foraminal stenosis with exiting L5 root impingement.

An MRI of the cervical spine dated 08/17/09 revealed very limited study due to motion artifact. There appeared to be multifactorial central canal stenosis C3-C4 through C5-C6 with the smallest AP canal diameter estimated at 6.5 mm at C4-C5.

A Designated Doctor Evaluation dated 12/21/09 indicated that the employee was lifting a heavy piece of equipment on the date of injury when it broke on him resulting in injury to his low back and left shoulder. The employee also reported injuring his neck. Treatment to date has included chiropractic/physical therapy, diagnostic testing, and medication management.

The employee was determined to have reached Maximum Medical Improvement (MMI) as of 12/21/09 with 0% impairment.

A Peer Review dated 08/24/10 indicated that the compensable injury was “some invisible nonspecific soft tissue injuries, at best a sprain/strain”. The MRI findings were not related to any particular incident or event including that of 07/29/09. All clinical treatment should have ceased within 8-12 weeks post incident.

A Designated Doctor Evaluation dated 09/17/10 indicated that the significant pathology identified on MRI would be preexistent. The extent of injury was a sprain/strain of the cervical area and possible sprain/strain of the lumbar area.

A Peer Review dated 04/19/11 indicated that the treatment in this case had served to perpetuate the subjective complaints. There was no credible evidence that any of the pathology observed on the cervical or lumbar films was directly caused by the event. The employee had not developed any consistent symptoms that specifically matched the pathology on the imaging studies. The employee had completed courses of physical therapy in the past that had not demonstrated any substantial benefit.

An orthopedic report dated 05/10/11 indicated that the employee underwent left shoulder arthroscopy on 05/04/11.

A Designated Doctor Evaluation dated 06/25/11 indicated that the employee had not reached Maximum Medical Improvement (MMI) noting that the employee was still undergoing physical therapy for the left shoulder; the employee still had ongoing cervicalgia with radiculopathy and ongoing low back pain with radiculopathy.

A discharge summary dated 07/21/11 indicated that the reasons for discharge were goals met; maximal level reached.

An Impairment Rating Evaluation dated 08/26/11 indicated that the date of statutory Maximum Medical Improvement (MMI) was 08/03/11 and 10% whole person impairment had been assigned.

A Peer Review dated 10/18/11 indicated that the employee for the most part, relative to any strain of the cervical, dorsal or lumbar spine should have recovered within an 8-12 week period. The findings on his diagnostic studies were consistent with normal degenerative findings. When first seen in the ER, the employee had no significant symptoms relative to his cervical spine and when subsequently seen initially by Dr. the employee had no evidence of a cervical radicular or lumbar radicular type syndrome. Future treatment was recommended to include a home exercise program. There was nothing to indicate that cervical injections or epidural steroid injections were indicated at that time. Similarly, lumbar injections were not indicated since the employee never had evidence of a significant acute lumbar radicular type syndrome and he has had primarily subjective complaints of pain well beyond what one would normally expect for this type of an injury. Therefore, continued epidural steroid injections this far post an injury that should have recovered would not be indicated.

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

An initial request for cervical epidural steroid injection was non-certified on 09/19/11 noting that epidural steroid injection was not recommended in the absence of radiculopathy. Physical examination on 09/02/11 indicated no evidence of cervical or lumbar radiculopathy. The compensable injury is limited to sprain/strain of the left shoulder and low back only. No further condition naturally resulted form or was affected by the original incident. The denial was upheld on appeal dated 10/11/11 noting that cervical spine MRI was suboptimal and does not support the multilevel loss of reflexes on the left. The employee's shoulder surgery was another source of pain to the neck and left shoulder and arm. The need for a clinical epidural steroid injection was not correlated by these records as there was no confirmation by an imaging study of a nerve root compression that correlates.

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

Based on the clinical information provided, the request for Injection with without contrast diagnostic therapeutic; fluor gid and Loclzj NDL/CATH SPI DX; epidurogram; Iedural lysis of adhesions is not recommended as medically necessary, and the two previous denials are upheld. The employee's physical examination failed to establish the presence of active radiculopathy, and the submitted cervical MRI failed to support the diagnosis. Current evidence based guidelines support the performance of epidural steroid injection only when radiculopathy has been documented on physical examination and corroborated by imaging studies and/or electrodiagnostic studies. Given the current clinical data, the request would not be indicated as medically necessary.