

# CASEREVIEW

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Notice of Independent Review Decision

**DATE OF REVIEW:** OCTOBER 14, 2011 AMENDED OCTOBER 19, 2011

**IRO CASE #:**

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

Left C5-6 ESI with Epidurography, Fluoroscopy, Sedation, Radiologic Exam

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

This physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

04/04/11: Evaluation by DO  
04/05/11: X-rays of the cervical spine interpreted by MD  
04/05/11: X-rays of the right knee interpreted by MD  
04/14/11: Evaluation by DC  
04/21/11: Re-evaluation by DO  
05/02/11: Re-evaluation by DO

05/13/11: MRI of the cervical spine without contrast interpreted by MD  
05/23/11: Re-evaluation by DO  
05/27/11: Evaluation by MD  
06/07/11: Evaluation by MD  
07/21/11: Re-evaluation by MD  
08/04/11: Evaluation by MD  
08/22/11: Re-evaluation by MD  
08/25/11: Functional Capacity Evaluation at  
08/29/11: MD performed a UR on this claimant  
09/08/11: Re-evaluation by DO  
09/13/11: MD performed a UR on this claimant  
09/16/11: Re-evaluation by MD  
09/23/11: Re-evaluation by MD

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who suffered injuries to her shoulders, elbows, knees, back and neck after falling on the floor.

On April 4, 2011, the claimant was evaluated by DO. Physical examination revealed an objectively unremarkable knee, muscle soreness to the low back, upper back, shoulders, cervical spine and both elbows. The left knee was painful. There were no objective findings in any of those areas except for muscle tenderness. Diagnosis: Sprain/strain of the neck, contusion of knee, sprain/strain of thoracic spine. Recommendation: Light duty, medication, physical therapy.

On April 5, 2011, X-rays of the cervical spine interpreted by MD: The lateral is under penetrated, and there was no AP odontoid view presented; the odontoid is not visualized; C7 is not visualized. There appears to be normal alignment without any disc space narrowing. The bony neural foramina appear to be normal sizes in all cervical levels. There is no acute fracture visualized nor any subluxation. The bones appear to be normally mineralized.

On April 5, 2011, X-rays of the right knee interpreted by: Demonstrated degenerative changes. There were no fractures, dislocations or soft tissue abnormalities identified.

On April 14, 2011, the claimant was evaluated by DC for the purpose of occupational/physical therapy for 6 visits.

On April 21, 2011, the claimant was re-evaluated by DO. Medications: Flexeril and over-the-counter anti-inflammatories.

On May 2, 2011, the claimant was re-evaluated by DO. It was noted the claimant's reported pain level was 9/10. Physical Examination: The claimant's pain complaints continue to be out of proportion to the clinical exam. She states that she is having severe neck pain but she appears to have near free ROM in

the cervical spine. The upper trapezius muscles are mildly painful with mild spasm bilaterally. She does complain of point specific tenderness again to the C6-7 spinous process area. Plan: MRI of the cervical spine. She was also prescribed Flexeril and Voltaren gel.

On May 13, 2011, MRI of the cervical spine without contrast interpreted by MD. Impression: 1. There is non-specific straightening of the usual cervical lordosis. There is mild disk dehydration from C2-3 through C6-7 with minimal loss of disk space height at C5-6 and C6-7. 2. There is posterior osseous ridging and accompanying disk bulging centrally and more to the left than right of midline at C5-6 and more to the right of midline at C6-7. There is partial effacement of the ventral subarachnoid space with just minimal flattening of the ventral cord surface at these locations. Left greater than right unciniate arthropathy and facet hypertrophy are present at C5-6 with mild to moderate foraminal stenosis on the left. There is mild foraminal stenosis on the right at C6-7. 3. There is no significant disk bulge or protrusion at the remaining cervical levels. The cord is not compressed or deformed at the remaining levels. There is no high-grade central or foraminal stenosis. 4. No intrinsic cord abnormality is identified.

On May 23, 2011, the claimant was re-evaluated by DO. It was reported that the complaints of discomfort before and during the exam were not consistent with the physical exam or the MRI findings. Dr. could not ascertain if the MRI findings are involved with the claimant's continued complaints of pain. On exam the claimant had mild tenderness and muscle spasm to the upper trapezius muscles bilaterally. She had FROM in the cervical spine with no alleged pain. There are no apparent motor or sensory deficits in the upper extremities. She has periodic complaints of knee and low back discomfort. Plan: Referral to orthopedics.

On May 27, 2011, the claimant was evaluated by MD. Physical examination: No posterior cervical tenderness, Spurling's maneuver is positive, sensory exam was intact to light touch in the upper and lower extremities, reflexes were equal and symmetric in the upper and lower extremities. Diagnosis: Cervical spondylitic radiculopathy, cervical HNP, and neck pain. Plan: Recommended home exercise protocol. Prescribed an Aspen traction collar along with referring her to Dr. to see if they can obtain cervical epidural steroid injections.

On June 7, 2011, the claimant was evaluated by MD. Physical examination: Cervical spine range of motion is intact. Spurling is positive causing pain down to her neck. Muscle strength was reduced of her wrist extensors of 5-/5. There was decreased sensation in her shoulder and lateral part of her arms. Reflexes were reduced in her biceps bilaterally at 1+. Diagnosis: Cervical radiculopathy and cervical disc bulges. Recommendations: Epidural steroid injection of the cervical spine as she has failed oral medication as well as physical therapy.

On July 21, 2011, the claimant was re-evaluated by MD. Physical examination: No change. Recommendations: As the ESI had been denied, an EMG/NCS was ordered.

On August 4, 2011, the claimant was evaluated by MD. It was noted that the claimant reported numbness and tingling in her left upper extremity along the lateral and ulnar side extending into her little and ring fingers. Physical examination: Bilateral paraspinalis muscle spasm and tenderness of the cervical spine with more on the left than the right. Motion of flexion was significantly compromised by pain with an increase in the tingling reported in her left upper extremity. The reflexes were normal and there were no radicular or other neurologic findings identified. There appeared to be gross weakness of the left sided grip. There may have been a decrease in sensation of the light touch to the ulnar side of the hand to include the little finger. There was a negative Tinel's and Phalen's testing. Diagnosis: She continues to have symptoms and findings compatible with left sided cervical radiculopathy. Plan: EMG, Ultram, and consultation with MD.

On August 22, 2011, the claimant was re-evaluated by MD. On physical examination: Cervical musculature was tender to palpation. Spurling's test was negative. Strength was 4/5 biceps, 5/5 elbow extension, and 4/5 wrist extension. Reflexes were biceps 1+, triceps 2+, and brachioradialis 1+. Sensation was decreased distally to pin. Plan: EMG/NCV and Cervical ESI.

On August 25, 2011, the claimant underwent a Functional Capacity Evaluation at ECCare. The results of the FCE were inconclusive due to having to end the test prematurely secondary to the claimant's complaints and her lethargy.

On August 29, 2011, MD performed a UR on this claimant. Rationale for Denial: Cervical ESI is not approved in the absence of radiculopathy (ODG).

On September 8, 2011, the claimant was re-evaluated by DO. It was noted that the claimant asked to be completely taken off work because of her pain. Dr. refused and placed her on Light duty. There was no change in physical findings. Medications: Flexeril and Vicodin.

On September 13, 2011, MD performed a UR on this claimant. Rationale for Denial: The report of C5/6 and C6/7 disc herniations by Dr. is not consistent with the official MRI report. Dr. noted inconsistency on her performance in the office and after she left the office. There is inconsistency of her reported findings. The lack of specific objective radiculopathy would not support this request.

On September 16, 2011, the claimant was re-evaluated by MD. Physical examination: Left sided paraspinalis muscle spasm and tenderness of the cervical spine extending through and including the left trapezius. ROM was compromised due to pain. The reflexes were normal and there were no radicular or other neurologic findings. Dr. was going to attempt to place her back at full duty.

On September 23, 2011, the claimant was re-evaluated by MD. It was noted that she had not returned to full duty as she was involved in a MVA in which her care was spun around. There was no change in physical examination.

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

The previous decisions have been upheld. Per the Official Disability Guidelines (ODG) the claimant does not meet the criteria for the use of cervical epidural steroid injections. There is not enough objective documentation to support radiculopathy and there is no documented electrodiagnostic evidence of radiculopathy.

ODG:

**Criteria for the use of Epidural steroid injections, therapeutic:**

*Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.*

- (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).
- (3) Injections should be performed using fluoroscopy (live x-ray) for guidance
- (4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.
- (5) No more than two nerve root levels should be injected using transforaminal blocks.
- (6) No more than one interlaminar level should be injected at one session.
- (7) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.
- (8) Repeat injections should be based on continued objective documented pain and function response.
- (9) Current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.
- (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
- (11) Cervical and lumbar epidural steroid injection should not be performed on the same day.

**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), and imaging studies have suggestive cause for symptoms but are inconclusive;
- (4) To help to identify the origin of pain in patients who have had previous spinal surgery.

**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)