CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: August 22, 2011 **Amended September 4, 2011**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization of epidurography), of diagnostic or therapeutic substances in.

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

This physician is Board Certified Physical Medicine and Rehabilitation with over 15 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

February 15, 2011, X-rays of the right shoulder read by MD. Impression: No acute process of the right shoulder.

February 15, 2011, X-rays of the lumbosacral spine read by MD. Impression: No acute process of the lumbar spine. Mild levoscoliosis of the thoracolumbar spine. Gastric lap band present.

March 21, 2011, Cervical spine CT with reconstructions. Impression: No evidence for fracture. Mild-moderate kyphosis. Small osteophyte at C4-5, otherwise unremarkable CT cervical spine.

March 21, 2011, X-rays right knee. Impression: No evidence of bony abnormality.

March 21, 2011, X-rays left knee. Impression: No evidence of bony abnormality.

June 2, 2011, MRI of the right shoulder read by MD. Impression: 1. Glenohumeral joint effusion and subacromial-subdeltoid bursitis. 2. Partial tearing involving a portion of the distal supraspinatus tendon as described specifically above. There are no complete rotator cuff tendon ruptures. 3. Mild acromioclavicular joint capsule hypertrophy.

On June 6, 2011, the claimant was evaluated at Anesthesia and Pain Management by DO with complaints of chronic, persistent neck, right shoulder, arm, and hand pain associated with swelling, sensitivity, and burning pain, as well as mid thoracic and bilateral knee pain. PE: Walks with an antalgic limp and cane support device. Neck was supple with decreased left and right rotation at 60 and 50 degrees, respectively. She was able to bring her chin within one inch of her chest with moderate neck pain with flexion. She had increased paraspinal muscle tone and trigger point tenderness throughout the cervical, interscapular, and rhomboid regions. She had exquisite subacromial bursa tenderness on the right. She had mild increased sweat production in her right hand with mild hyperesthesia and allodynia throughout the right upper extremity as compared to the left. Palpation of both knees revealed Drawer's testing was negative and McMurray's testing was negative. She had mid patellar tracking pain with compression testing positive. Deep tendon reflexes were 1+ in the upper and lower extremities bilaterally. No ankle clonus was elicited. Trigger pint tenderness in the mid thoracic region was also noted. Diagnosis: 1. Chronic neck pain syndrome with pain radiating into her right shoulder, arm and hand. Cannot rule out cervical disk disorder following fall injury while at work. 2. Posttraumatic sub deltoid bursitis of the right shoulder with partial tendon tear. 3. Myofascial pain syndrome of the cervical, mid thoracic, and lumbar regions secondary to #1. 4. Cannot rule out prepatellar bursitis of the knees following traumatic fall injury. 5. Moderate reactive depression and anxiety in a chronic pain state. Plan: Get her off skeletal muscle relaxant therapy. Titration of her Cymbalta in conjunction with potent narcotic analgesia MS-Contin which will be increased to 30 mg t.i.d. will be prescribed. Continue her with neuropathic pain medicine Neurontin. Discontinue Soma over the next two to three weeks and add Clonazepam at night.

On June 29, 2011, M.D. performed an UR on the claimant. Rationale for Denial: The history and documentation do not objectively support the request for an ESI to the cervical spine in the absence of clear evidence of radiculopathy on physical exam and/or EMG have been reported.

On July 7, 2011, the claimant was re-evaluated at Anesthesia and Pain Management by DO who recommended central cervical epidural blockade for persistent shoulder, arm and hand pain consistent with a cervical disk disorder.

On July 15, 2011, M.D. performed an UR on the claimant. Rationale for Denial: No documentation was submitted regarding the claimant's imaging studies confirming the claimant's radiculopathy component.

On July 21, 2011, the claimant was re-evaluated at Anesthesia and Pain Management by DO who noted she was emotionally distraught, despondent. She was requesting her Naprosyn. Due to persistent neck, shoulder, and arm pain associated with hyperesthesia and all consistent with CRPS, Dr. recommended central cervical epidural blockade to be instituted at once. PE: She had moderate hyperesthesia and allodynia. She had extreme trigger point tenderness in the right neck, shoulder, and arm. She had marked decreased neck range of motion and moderate cervical interspinous tenderness.

PATIENT CLINICAL HISTORY:

The claimant was at work when a tire fell down off a roll and hit her neck and right shoulder.

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

Denial of cervical ESI is upheld. Per the ODG Neck Chapter Criteria #1 and #2 are not met. Submitted clinicals do not document a clear radiculopathy on physical exam and there is no corroboration by imaging study. Furthermore, submitted clinicals do not indicate success or failure of previous treatments such as PT/exercise or NSAIDS.

ODG:

Criteria for the use of Epidural steroid injections:

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 be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)
8) 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.
9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block.

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)