



Notice of Independent Review Decision

DATE OF REVIEW: 04/16/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inj Foramen Epidural C/T 64479
Inj Foramen Epidural Add-On 64480

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

Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain Medicine

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.

Inj Foramen Epidural C/T 64479 – UPHELD
Inj Foramen Epidural Add-On 64480 – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Designated Doctor Evaluation (DDE), M.D., 03/28/07
- Impairment Rating Review, M.D., 04/11/07
- Medical Record Review, M.D., 05/06/07
- DDE, M.D., 05/19/08
- DDE, Evaluation Center, 09/10/09
- Cervical Spine MRI, M.D., 10/27/11
- Detail Notes, 12/11/11
- Follow Up, Pain Consultants, 01/24/12, 03/05/12, 03/12/12
- Pre-Authorization, Pain Consultants, 03/05/12
- Denial Letters, 03/08/12, 03/19/12
- DDE, M.D., 03/19/12
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

Services in dispute include injection foramen epidural (CPT code 64479) and injection foramen epidural add-on (CPT code 64480). Upon independent review, the reviewer finds that the previous adverse determination/determinations should be upheld.

This patient was allegedly injured on 03/07/06 in the scope of her normal duties as a. While attempting to detain a driver, the driver struggled with the patient, sped away, dragging and running over the patient. The patient sustained compensable injuries to her right shoulder, bilateral knees, right hip, upper and lower back, neck, and right tooth.

An Independent Medical Examination was performed by Dr. on 03/28/07. He noted that the patient had been released to full duty work as of 06/19/06 and was working as of 01/19/07. The patient had a previous medical history of previous surgeries to her right shoulder in 2003, right knee surgery in 2006, and left knee surgery in 1998. Physical examination documented normal cervical range of motion with no palpable tenderness. Both shoulders demonstrated good range of motion with no limitations. The lumbar spine demonstrated no signs of limited range of motion, and the hips and right knee all had good range of motion, as well. The patient was found to be at Maximum Medical Improvement as of 03/28/07 and was awarded a 0% whole person impairment rating.

A Designated Doctor Evaluation was performed by Dr. on 05/19/08. Dr. reviewed medical records to that point, including thoracic, cervical, and lumbar MRI scans. The lumbar MRI scan on 04/11/06 demonstrated left L4-L5 annular tear with L4-L5 and L5-S1 facet hypertrophy and only minimal L5-S1 bulge. The cervical MRI scan, also on 04/11/06, demonstrated mild C4-C5 and C5-C6 disc degeneration only. Thoracic MRI scan demonstrated only mild bulges at T1-T2 and T2-T3. On 01/15/07 lower extremity EMG/nerve conduction studies were found to be normal. On 08/27/07 upper extremity

EMG/NCV studies were found to be similarly normal. Dr. noted the patient's chief complaints involving five separate areas. She noted the patient's dental injury was no longer of any concern and had been repaired. She stated the patient still had pain in the back of her skull radiating to the midthoracic area and occasional pain radiating to the right arm. Physical examination, however, demonstrated no paravertebral muscle spasm, supple neck, and no motor or sensory deficits. The low back complaint was of sacral pain radiating to the right calf. The Patrick test was negative as was supine straight leg raising test. There was no atrophy in either leg. The patient complained of stiffness and aching in the right shoulder with nonspecific decreased range of motion on examination. No motor, sensory or vascular deficits were noted in the upper extremities. Finally, the patient stated that her bilateral knee pain was much improved after surgeries. She was noted to walk with a normal gait, and the lower extremities demonstrated no edema or effusion. The knees demonstrated no laxity or decreased range of motion. Dr. awarded the patient a 12% whole person impairment rating with statutory MMI on 03/07/08.

On 05/12/11 the patient was seen by Dr. for ongoing complaints of right mid and lower neck aching. The patient was taking Lyrica 200 mg at night and an occasional over-the-counter anti-inflammatory medication. She also complained of stabbing pain at the right base of the skull. Physical examination documented right mid and lower neck tenderness over the posterior articular pillars with normal strength and sensation. Recommendation was made for right C4-C5 and C5-C6 facet joint injections.

On 10/27/11 a cervical MRI scan was performed at the request of Dr.. That cervical MRI scan demonstrated a LEFT C5-C6 lateral disc protrusion without nerve compression. The patient's pain, however, was listed as radiating to the RIGHT upper extremity.

Dr. followed up with the patient on 01/24/12, noting only her continued axial, mid, and lower neck pain, somewhat worse on the right. Dr. noted the patient had previously undergone right C3 through C6 facet rhizotomy on 12/08/06 and again in the fall of 2007. The patient complained of right upper cervical pain radiating to the mid neck and aching in the upper thoracic spine. The patient's pain level was 1.3/10. Physical examination documented no restrictions in cervical range of motion, negative Hoffman and Spurling signs bilaterally, normal brachioradialis and triceps reflexes bilaterally, normal sensation throughout both upper extremities bilaterally, and normal strength in both upper extremities and all muscles tested bilaterally. There was tenderness to the upper and mid cervical facets. Dr. noted the patient had undergone right C2-C3 and C3-C4 facet medial branch blocks on 08/04/10, providing approximately 70% relief for about six weeks. He also noted the patient had subsequently undergone radiofrequency treatment of the right C2-C3 and C3-C4 facet joints on 01/26/11 with five months of 60-70% relief. Repeat medial branch blocks at the same levels were performed on 09/26/11, providing 70% relief through 10/13/11. Dr. then reviewed the MRI scan from 10/27/11, demonstrating C2-C3 through C4-C5 mild facet joint degeneration and left C5-C6 lateral stenosis. He then requested C7-T1 intralaminar epidural steroid injections.

On 03/05/12 Dr. followed up with the patient again, noting only her axial neck complaints and no complaints of radiation of pain into the right upper extremity. The

pain level was exactly the same, and the physical examination was still essentially entirely negative with no change. Dr. again recommended C7-T1 intralaminar epidural steroid injection.

Initial Physician Adviser Review on 03/08/12 recommended non-authorization of the request, citing MRI scan findings of normal disc height and no disc herniation at C7-T1 and no physical examination evidence of radiculopathy.

Dr. followed up with the patient on 03/12/12, documenting the same axial neck complaints without any mention of limb symptoms. Pain level and physical examination were again identical to the previous two visits. Dr. noted that the procedural request had been denied and appealed that decision.

An Independent Medical Examination was then performed on 03/19/12 by Dr. who noted the patient's complaint of neck pain radiating to the upper thoracic area and right periscapular region. Physical examination documented no clinically significant limitations in range of motion of the cervical spine with any limitation "appearing to be secondary to voluntary muscle guarding." Sensation was normal in both upper extremities, as were deep tendon reflexes in both arms. Dr. stated that any treatment subsequent to 03/28/07 was not medically reasonable or necessary and that no further treatment would be appropriate for the work injury, nor would any further medications be justifiable.

A second Physician Adviser Review of Dr. procedure request on 03/19/12 also recommended non-authorization, citing ODG Guidelines, lack of physical examination evidence of radicular findings, and lack of MRI scan evidence of pathology.

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

According to ODG Treatment Guidelines, epidural steroid injections are medical reasonable and necessary when several factors are present. First, there must be MRI scan evidence of disc herniation causing nerve root compression as well as physical examination or electrodiagnostic study evidence of radiculopathy. In addition, epidural steroid injections are considered reasonable and necessary to treat radicular pain. In this case, none of those factors are present. The patient has no complaints of radicular pain, no physical examination evidence whatsoever of radiculopathy or, for that matter, any neurologic deficit, and no MRI scan evidence of disc herniation causing nerve root compression. Therefore, this patient is not an appropriate candidate for the requested procedures of injection foraminal epidural and injection foraminal epidural add-on (CPT codes 64479 and 64480). The patient does not meet ODG criteria for either of these procedures, nor does the claimant meet any nationally accepted medical standards or criteria for epidural steroid injections. The previous Physician Advisers' recommendations for non-authorization of the requested procedures are, therefore, upheld.

**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)
- AMA GUIDES 5TH EDITION