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Notice of Independent Review Decision

DATE OF REVIEW: May 30, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat cervical epidural steroid injection (ESI) at C7 and 12 sessions of PT.

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

Board Certified AAPMR and Subspecialty Board Certified in Pain Medicine.

REVIEW OUTCOME

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

x Upheld (Agree)

Medical documentation does not support the medical necessity of the health care services in dispute.

☐ Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

☐ Partially Overturned (Agree in part/Disagree in part)

Note: There are to be no partials in Prospective/Concurrent cases, unless there is more than 1 denied services

Medical documentation partially supports the medical necessity of the health care services in dispute.

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI

- Reviews (04/19/12 – 05/01/12)

- Diagnostics (03/22/99 - 03/12/12)
- Office visits (01/12/11 – 04/09/12)
- Procedure (03/05/12)
- Reviews (04/19/12 - 05/01/12)

D.O.

- Diagnostics (03/22/99 – 07/01/99)
- Office visits (02/03/03 – 12/15/10)
- Procedures (11/20/06 – 03/05/12)
- Reviews (04/19/12 – 05/01/12)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who on xx/xx/xx, injured his back when a tree limb fell on his back.

: In March, magnetic resonance imaging (MRI) of the cervical spine showed bulging discs at C4-C5, C5-C6 and C6-C7. There was left foraminal narrowing at C5-C6 and C6-C7 due to degenerative changes with mild compression of the nerve root and there were minimal old compression deformities of T2 and T3 vertebral bodies with spinal canal involvement.

In July, the patient underwent cervical myelogram that showed mild left nerve root compression at C6-C7 possible secondary to foraminal stenosis, bulging disc and/or osteophytes slightly compressing the ventral subarachnoid space and very minimal left nerve root compression at C5-C6. Post myelogram computerized tomography (CT) scan of the cervical spine showed mild compression of the left nerve root possibly due to foraminal stenosis and diffuse bulging of the disc.

2000 – 2002: No records are available.

2003 – 2006: From February 2003, thorough December 2006, the patient had monthly follow-ups with D.O. for the complaints of pain in neck radiating into the left upper extremity. It was noted that the patient had undergone first cervical epidural steroid injection (ESI) which had helped him significantly. The patient reported some discomfort. He was utilizing medications such as MS Contin, Soma, hydrocodone and Mobic. It was noted that the patient had weakness in his left upper extremity especially in the grip of his left hand. Dr. assessed cervical radicular pain and refilled medications.

In March 2003, it was noted that the patient had undergone second and third cervical ESI which had helped significantly with neck and left upper extremity pain. The patient was maintained on MS Contin, Soma, Lorcet and Mobic.

In May 2003, the patient reported pain in his neck radiating to his left upper extremity. He reported that the medications were not helping with the pain. He had cervical ESI with some relief in the month of October, November and December.

In January 2004, the patient reported that the cervical ESI did help him to some extent. He also reported that medications were giving him adequate pain relief.

In December 2004, it was noted that the patient had undergone a cervical ESI. He continued to receive refills of MS Contin, Soma, Lorcet and Mobic.

In January and February 2005, the patient had cervical ESIs. Dr. maintained the patient on MS Contin, Soma, Lorcet, Mobic and Elavil. The patient received monthly medication refills from January through December 2005. Dr. had recommended cervical ESI but it was denied on several occasions.

In November 2005, the patient reported pain in his neck and left arm and some worsening weakness in his left upper extremity. He reported that the current medical therapy was not giving him relief of his discomfort. Dr. refilled pain medications.

From January through December 2006, the patient received monthly refills for MS Contin, Soma, Lorcet, Mobic and Elavil.

In February 2006, it was noted that the patient had undergone cervical ESI following which he reported stomach upset and nausea. Dr. recommended continuing medications.

In March, the patient reported slight worsening of the burning sensation in his foot. The patient requested that he would want to go for a repeat cervical ESI.

From November through December, the patient had three cervical ESIs. On follow-up, he reported that he was doing very well with his current regimen especially since he has had his injections done in the neck area.

2007 – 2010: From January through December 2007, the patient was under the care of Dr. He received regular medication refills. The patient reported having 50% relief of his discomfort.

In June, the patient reported that the pain had returned. He reported that his ongoing medication regimen had been helping him.

In November 2007, the patient received three cervical ESIs with some benefit. He reported overall his pain had improved with medications. He continued to utilize medications such as Soma, Elavil, Mobic, Lorcet and MS Contin.

In January 2008, the patient reported that radicular symptoms that he had been experiencing prior to the injections had completely resolved and he had no new complaints. The patient had monthly follow-up visits with Dr. and received refills of medications.

From January through December 2009, the patient was under the care of Dr. . He reported slight increase in his pain. He was maintained on MS Contin, Lorcet, Soma, Elavil and meloxicam. It was noted that the patient's pain was well controlled with the ongoing medication regimen.

In October 2009, the patient had limited range of motion (ROM) with lateral rotation and extension in the cervical area. He reported mild-to-moderate pain in neck region.

In November 2009, Dr. opined that the patient was disabled and was unable to work at that time due to injury to his neck. The patient was treated conservatively with occasional injections in his neck as well as his current medical therapy which included MS Contin, Mobic, Elavil, Soma and hydrocodone for breakthrough pain. The patient reported good pain control with mild-to-moderate severity of pain.

In January 2010, Dr. noted that the patient was able to do all of his activities of daily living (ADLs) with very minimal breakthrough pain which was well-controlled with medications and he had no new complaints. The patient continued to have limited ROM in the cervical area. He had slight increase in his pain as he was moving. However, he reported that it was manageable.

In June, the patient reported an episode when he had leaned into his vehicle to help him relax and when he stood upright he passed out. Dr. noted that the history was positive for hypertension. The patient reported that secondary to his fall, he landed on his right shoulder posteriorly and had little soreness and muscle pain in the trapezius area. He had limited ROM in the lateral rotation of the cervical area and some tenderness to light touch and palpation of the trapezius muscle and the glenohumeral area. Dr. opined that the patient needed to be evaluated by his primary care physician (PCP). The patient underwent urine drug screen (UDS) which was positive for hydrocodone and morphine indicating that the patient was compliant with the prescribed medications.

On follow-up, Dr. noted that the patient had limited ROM in the lumbar area. The patient received treatment for chronic cervicalgia and secondary low back pain. His pain was well controlled with MS Contin and Lorcet. He continued to utilize Soma and meloxicam as needed for his pain as well as Elavil at bed time.

2011 – 2012: From January through November 2011, the patient was evaluated by Dr. for his neck and back complaints. Dr. noted that the patient was able to do all of his ADLs with no difficulty. His pain was well-controlled with medications.

The patient was maintained on MS Contin, Soma, Mobic, Elavil and Lorcet. He received monthly refills for these medications. The patient underwent urine drug screen which showed that the patient was compliant with his prescribed medications.

In August, the patient reported numbness to the medial aspect of his right elbow and numbness radiating down the medial aspect of the forearm consistent with ulnar nerve distribution. He reported more pain in the cervical area and thoracic musculature. Examination showed slightly limited ROM. Dr. assessed low back

pain, cervicalgia, cervical radicular pain and right cubital tunnel syndrome. He recommended considering injection for cubital tunnel syndrome and prescribed prednisone, Mobic, Soma, Elavil, Lorcet and MS Contin.

On follow-up, the patient reported that steroid Dosepak was helpful with his radiating pain in the ulnar nerve. He reported that the paresthesia was near the tip of the 5th digit. It was noted that the patient had history of fracture in the radial ulnar area which required open reduction internal fixation (ORIF). The patient had developed osteomyelitis. The hardware was removed and ultimately replaced. Dr. opined that the ulnar nerve issue could be related to cubital tunnel syndrome or possibly related to the hardware in that area. He recommended neurologic evaluation and nerve conduction study (NCS) and considering x-ray of the forearm.

On February 13, 2012, the patient reported increased pain in his right upper extremity and noticeable paresthesia in the 4th and 5th digit of the right hand with pain also in the same area on the forearm which was consistent with a C7-C8 dermatome. PA noted altered sensation over the 4th and the 5th digit consistent with paresthesias and a positive Spurling's test to the right. The patient received refills for his ongoing medication.

On March 5, 2012, Dr. performed cervical ESI.

On March 12, 2012, Mr. noted that there was no noticeable relief at that point. The patient reported that in the past when he had an ESI done it took several weeks before he noticed improvement. The patient's medications were refilled. The patient underwent a urine drug screen which was positive for the prescribed medications such as morphine and hydrocodone.

On April 9, 2012, Dr. noted that the patient had experienced improvement in the area of injection and improved grip strength. However, he was still experiencing paresthesia in the ulnar nerve distribution of the right forearm. Examination revealed paresthesia on palpation of the C7-C8 dermatome. Dr. recommended one more cervical ESI targeting the C7 area followed by physical therapy (PT).

Per utilization review dated April 19, 2012, the request for repeat cervical ESI at C7 and 12 sessions of PT was denied with the following rationale: "*The treating provider is requesting to proceed with a repeat cervical epidural steroid injection at the C7 level as well as physical therapy at three times a week for four weeks to the right forearm to hand. The physical examination findings do not document the presence of a radiculopathy. There is documentation of some decreased sensation in a specific dermatomal pattern but no documentation of any loss of strength or loss of sensation to support clinical findings of radiculopathy. Additionally, there are no imaging studies or diagnostic studies included in the records presented to be reviewed to support any neurological compression. Treatment guidelines would not support proceeding with an epidural steroid injection unless there were objective physical examination findings of radiculopathy which must be corroborated by imaging studies documenting nerve compression. Additionally, the claimant has recently undergone an epidural steroid injection and the records do not reflect any decreased use of medications or increased function following the injection procedure. The percentage of improvement following the injection and length of time that the claimant benefited*

is not listed. Treatment guidelines would not support a repeated injection unless there was at least a 50 percent improvement in symptoms for a period of 6-8 weeks time documented with decreased use of medication and increased function which is not evident in the records submitted to be reviewed. Additionally, the treating provider is requesting physical therapy for the right forearm and hand, however there are no functional findings involving the hand to support formal physical therapy at this time as opposed to a self directed home exercise program. The claimant is noted to have an injury dating back to xxxx and should be well versed on a self directed home exercise program for range of motion and strengthening exercises of the right upper extremity. Although, treatment guidelines do support 1-2 visits of therapy following a cervical epidural steroid injection, the treating provider's request exceeds those visits and it's not specifically being requested due to the claimant undergoing and epidural steroid injection and therefore the request cannot be certified."

Per reconsideration review dated May 1, 2012, the appeal for repeat cervical ESI at C7 and 12 sessions PT was denied with the following rationale: *"This is an appeal for a repeat cervical ESI to C7 and 12 PT visits to the right forearm and hand. It is noted that the previous request was non-certified due to lack of physical findings of radiculopathy, lack of documentation of decreased use of medications or increased function after the recent ESI, and no functional findings involving the hand to support formal physical therapy. Updated documentation elaborates imaging studies of the patient, but was performed in 1999. There was still no recent documentation of physical findings suggestive of radiculopathy in this patient as well as identification of functional deficits of the right forearm and hand. There was lack of recent imaging or electrodiagnostic studies to corroborate with the physical examination findings were still not provided. There was still no objective documentation of the patient's clinical and functional response from the previous ESI that includes sustained pain relief of at least 30-70 percent for at least six to eight weeks, increased performance in the activities of daily living and reduction in medication use. Furthermore, there was no objective documentation of failure of any interim conservative care such as an optimized pharmacotherapy in this patient, utilizing VAS scores with and without medication intake, and active rehabilitation efforts. Likewise, there was no indication that the requested injection will be used in adjunction to facilitate progress in more active treatment programs. In addition, the chronicity of the patient's neck pain and smoking habit are considered negative predictors to the success of the contemplated injection. Regarding the request for PT, the specific short term and long term goals that address the requested service were not provided. There was also no indication that the patient is to progress into the performance of an independent home exercise program. Hence, the previous non-certification is upheld."*

On May 7, 2012, Dr. noted that the patient had no new complaints. Dr. refilled Lorcet, Soma, meloxicam, amitriptyline and MS Contin.

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

Epidural steroid injections are indicated for radicular pain but not in a series of 3. Radicular pain must be relieved 50-70% for a 6-8 week period before an additional ESI is indicated. No more than 4 blocks per region per year is indicated.

I agree with the above statement. However, there is evidence of an ulnar neuropathy of the right arm, but no documented physical examination evidence of a cervical radiculopathy .
In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for 6-8 weeks with a general recommendation of no more than 4 blocks per year. There is no documentation of 50% or greater relief for more than 6-8 weeks.
Thus with no documented evidence of a cervical radiculopathy and failure to meet criteria for a repeat injection, no additional Cervical Epidural Steroid injections can be recommended at this time.

1-2 sessions of physical therapy is recommended after an epidural steroid injection. Thus additional physical therapy is denied.

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

IF YOU ARE NOT UTILIZING THE ODG GUIDELINES YOU MUST STATE WHY, PER TEXAS DEPARTMENT OF INSURANCE.

- ☐ **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)**