

Icon Medical Solutions, Inc.

11815 CR 452
Lindale, TX 75771
P 903.749.4272
F 888.663.6614

Notice of Independent Review Decision

DATE: October 3, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

62310 Injection, W/WO Contrast; Diagnostic/Therapeutic, Cervical

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

This physician is Board Certified by the American Board of Orthopaedic Surgeons with over 40 years of experience.

REVIEW OUTCOME:

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

Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

02/20/12: Consultation by
03/19/12: MRI of the Cervical Spine report
04/02/12: Office Visit
04/16/12, 05/15/12, 06/04/12: Office Visit
07/05/12: Lumbar Procedure Report
07/18/12: Office Visit
08/06/12: Fax
08/13/12: UR
08/17/12: Office Visit
09/07/12: UR

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured at work on xx/xx/xx. He is status post left rotator cuff repair, left carpal tunnel release, and ACDF.

02/20/12: The claimant was evaluated for complaint of left shoulder pain. It was noted that he was in a classroom on 10/10/11 when he was pushed from behind

and landed on the edge of a door causing immediate pain that was mild at first but worsened by the next day. On physical exam, there was no swelling, tenderness, or cyanosis of the extremities. The right shoulder ROM was without pain. Left shoulder abduction (A) 160 (P) 160, adduction (A) 35 (P) 35, flexion (A) 160 (P) 160, extension (A) 50 (P) 60, internal rotation (A) 50 (P) 50, external rotation (A) 35 (P) 35. On gait testing, he had normal stance and swing phase. On neck exam, he held his head erect and perpendicular to the floor. The neck moved in smooth coordination with the body/motion. There was no tenderness or mass around the cervical paravertebral musculature. There was painful cervical ROM with flexion, with extension, and with right lateral bending. Negative compression test, distraction test, Adson's test, Spurling's test, and Valsalva's test. On neurological testing, upper extremity motor testing was 5/5. Upper extremity DTRs were as follows: Biceps, right 2/4, left 1/4. Brachioradialis, right 2/4, left 2/4. Triceps, right 2/4, left 2/4. Sensation was intact in the upper extremities. There was negative Hoffman's sign, Adson's maneuver, Tinel's sign, and Phalen's test in the upper extremities. X-ray of the left shoulder revealed a suture anchor. ASSESSMENT: Supraspinatus syndrome, left. Lumbago. Lumbar herniated disc. Lumbar radiculopathy. Cervical radiculopathy. PLAN: The anti-inflammatory medications and muscle relaxants should be taken as prescribed. A cervical MRI will be done in order to better evaluate his symptoms and the spinal canal, discs, nerves, spinal bony anatomy, spinal cord, and paravertebral soft tissues. The patient has always presented and complained of pain radiating from the neck to the left shoulder and the mid-scapular area since the 10/11/11 injury. The shoulder has been thought to be the source of pain. I think the shoulder is definitely involved; however, he also presents with cervical radiculopathy. The cervical spine should also be an injured body part from the 10/11/11 injury. The patient has done well with chiropractic care. He was given a left subacromial steroid injection in the office. He was given prescriptions for Relafen and Soma.

03/19/12: MRI of the Cervical Spine interpreted. IMPRESSION: Multifactorial changes C4-C5 producing moderately severe canal stenosis. ACDF with anterior compression plate C3-C4 and C5-C6 with wide patency to the canal at both levels. C6-C7 interbody grafting with wide patency to the canal and foramina.

04/02/12: The claimant was reevaluated for complaints of left shoulder pain. It was noted that he had neck pain with radiating of pain to the trapezius and shoulders. On physical exam, the left shoulder had tenderness by the bicipital tendon as well as the greater tuberosity. Impingement sign was positive. External rotation was painful. Range of motion of the neck was painful. The left biceps had 4/5 strength. The left triceps reflex was 1/2. Otherwise, his upper extremity neurological exam was normal. Cervical MRI dated 03/19/12 showed moderately severe spinal canal stenosis of C4-C5 secondary to herniated disc and a spur. ACDF with well decompressed spine at C3-C4, C5-C6, and C6-C7. PLAN: I would like to do therapy and strengthening exercises of the left shoulder, neck, and lower back. I will give the patient Relafen b.i.d. and Soma ½ pill in the morning and 1 at night. I offered him a left shoulder cortisone injection. A C4-C5 epidural injection is indicated as well as a left L5-S1 epidural injection. The patient was asymptomatic before the 10/11/11 injury. His shoulder, neck, and

lumbar symptoms are directly related to the work-related injury. He was given a left shoulder steroid injection in the office.

04/16/12: The claimant was evaluated for complaints of constant posterior cervical pain that radiated into the occiput region and into the left parietal aspect of the head as well as the left trapezius. The left shoulder injection provided improvement of the shoulder pain, but not relief of the symptoms. He also reported numbness, tingling, fatigue, and tightness of the lateral aspect of the arm with tingling and weakness of the first, second, and third fingers. On physical exam, he had guarded movement that was exacerbated on bilateral rotation and extension. There was tenderness of the paraspinal muscles, left trapezius, left deltoid, and left biceps. The upper extremities had a decreased strength of the left biceps of 4/5. There was a diminished left biceps reflex and decreased sensation along the left lateral arm and the left radial aspect of the forearm. The left shoulder had a guarded movement that was exacerbated with pain with external rotation and abduction. There was a positive Neer's, positive Hawkins, positive drop-arm test, and a positive impingement test. PLAN: The patient continues to struggle with his symptoms and limitations of activities. At this point, the insurance company has not provided any of the prescribed medications or treatment. We received information that the case is under dispute, yet rationale is that there is no neurological pattern or presentation that would match the MRI. At no point did he say that there was no pathology since the MRI is more than the obvious as to the need for this epidural injection. The symptoms have now become more aggressive with sufficient neurological changes to affect the previously requested epidural injection follows the dermatomal pattern. The patient stated that he will bring the MRI that was done of his left shoulder and lumbar spine for further evaluation, but as far as this case is concerned, nothing has been done to help this patient's symptoms for a very well documented work-related injury where he was assaulted and caused multiple injuries.

05/15/12: The claimant was reevaluated for complaint of posterior cervical pain radiating into the left trapezius and mid-scapular region. It was noted that the pain could reach levels of 8/10. He continued to have numbness, tingling, and fatigue of the lateral aspect of the arm that radiated through the radial aspect of the forearm and into the first three fingers. On physical exam, the cervical spine had a guarded movement that exacerbated on left rotation, extension, and bilateral tilt. There was tenderness of the left rhomboids, left trapezius, and left deltoid. The upper extremities still had a decreased strength of the left biceps of 4/5 with a diminished left biceps reflex and also a decreased sensation on the left lateral arm. The grip strength was symmetrical with a negative Tinel's bilaterally at the elbows and wrists. PLAN: As far as the cervical pathology is concerned, we will request a C4-C5 epidural injection to be both diagnostic and therapeutic for his cervical pathology. He is encouraged to stay active and stretch regularly, but still try to avoid any kind of direct heavy lifting.

06/04/12: The claimant was reevaluated after continued physical therapy, which considerably helped his left shoulder. He still had reproducible pain with activity and functions. He had developed some left trapezius pain that was constant and

variable depending on the activity. On physical exam, the cervical spine had a guarded movement that exacerbated on extension, left rotation, and bilateral tilt. There was tenderness of the left rhomboids, left trapezius, left deltoid, and left anterior aspect of the shoulder. The upper extremities still had a decreased strength of the left biceps of 4/5 with a decreased left biceps reflex. There was also a decreased sensation along the left C5 dermatome. Tinel's sign was negative at the wrists and elbows. PLAN: As far as the previously requested cervical epidural injection, we received a denial with the rationale that according to, no specific level of the cervical epidural injection was identified. This is not only a great mistake, but an obvious biasness of this information. It is very clearly specified on the last office note that a C4-C5 epidural injection is requested to coincide with the pathology identified in the cervical MRI. To ignore the fact that this is mentioned is either the insurance company that did not provide with the necessary information, or he just clearly chose to ignore it. It is the very last paragraph of the last note dated on 05/15/12. Considering that the patient has a well documented lumbar and cervical pathology, we would like to also proceed with an EMG and NCS of both upper and lower extremities to clearly document the need of neurological involvement based on the symptoms. It is important that he maintains proper body mechanics, avoids exacerbating factors, and continue with his physical therapy since it has been so helpful to him.

07/18/12: The claimant was reevaluated status post left-sided L5-S1 epidural injection on 07/05/12. It was noted that he still had not had the cervical epidural injection approved from the insurance company, although there was "a significant cervical pathology that is not being addressed by the insurance company." The EMG of the upper and lower extremities had not been performed as "we are pending these results." On physical exam, the cervical spine had guarded movement. There was tenderness of the left trapezius and rhomboids radiating to the left deltoid. There was a decreased sensation on the left C4 and C5 dermatome. There was also weakness of the left triceps to 4/5 and asymmetrical grip strength, the left being weaker than the right. There was negative Tinel's sign at the wrists and elbows. PLAN: As far as the cervical symptoms are concerned, we would like to still proceed in an attempt to get approval for the cervical epidural steroid injections. It is more than obvious that the patient has great results from this type of procedures, but the insurance company always seems to disregard the great diagnostic value of the injections. The cervical MRI clearly depicts the significant cervical pathology that needs to be addressed. He has significant neurological changes to the upper extremities that should not be ignored. We would also like to receive the approval for the bilateral upper and lower extremity EMG and NCS to establish the neurological conditions.

08/13/12: UR performed. RATIONALE: Based on the medical records submitted for review on the above referenced claimant, cervical ESI is not approved. Claimant does not meet ODG criteria. He does not have radiculopathy. Exam by on 02/20/12 noted negative compression, Adson's Spurling's and Valsalva's tests. MS of UE normal. Reflexes of UE symmetric except left biceps C5-C6. Sensation normal. Special tests of UE are normal. 07/18/12 – OV – Post ESI L5-S1 on 07/05/12. Complete relief of 100% for 5 days. After this, symptoms

returned including buttocks with cramping of the left leg posteriorly. EMG of both UE and LE is pending. PE – slow guarded movement without any lumbar pain. Still has guarded lumbar motion, minimal hyperesthesias along the left posterior thigh as the left hip flexor fatigue continues. Still weakness of the left EHL and anterior tibialis of 4/5 and decreased left Achilles reflexes. Cervical guarded ROM. Tenderness of left trapezius and left deltoid. Decreased sensation of left C4-C5, weakness of left triceps 4/5, left grip strength is weaker than right. Cervical MRI – 03/19/12 – C3-C4 graft with wide patency of canal and foramina, C4-C5 disc bulge with facet arthrosis with moderate-severe canal stenosis, C3-C6 artifact with screws, wide patency of canal and foramina, C6-C7 wide patency of canal and foramina. ODG- Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.

08/17/12: The claimant was reevaluated. The transcribed note indicates: “Unfortunately, from the previously requested procedures to help with his diagnosis and treatment, there was a massive confusion on the information interpreted who transposed information from other patient on to this particular patient’s history as well as procedures that are being requested.” It was noted in the office that he continued to struggle with the posterior cervical pain, left trapezius pain, and left arm pain. He had pain, numbness, and tingling along the radial aspect of the arm and the first two fingers of the left hand. The EMG that was requested of both upper and lower extremities was “also denied by the same physician with further confusion of information what looks like a transposed information from another patient on to this particular case.” On physical exam, he ambulated with a slow gait. The cervical spine had guarded movement that exacerbated on bilateral rotation and extension. There was tenderness of the left paraspinal muscles and left trapezius as well as the rhomboids. The upper extremities had a decreased sensation on the left C4 and C5 dermatomes with weakness of the left triceps and a decreased left grip strength compared to the right. Tinel’s sign was negative at the wrists and elbows. PLAN: The cervical epidural injection was also denied with this statement that this patient does not meet the ODG guidelines in criteria because he does not have radiculopathy. However, on the note, it clearly states the multiple radicular symptoms of this patient that not only covers neurological but motor function deficits throughout. goes on to mention multiple information that are consistent with lumbar pathology that have nothing to do with this requested patient’s cervical epidural injection as well as lower extremity radicular symptoms that are not particularly this patient’s history for this pathology. Therefore, at this point we will submit for a reconsideration on the cervical epidural injection to be both diagnostic and therapeutic as the patient has not had one as of yet and considering his cervical pathology as well as his upper extremity radicular symptoms, this epidural injection is indicated. The EMG and NCS of both upper and lower extremities were also denied with his rationale that this patient’s injury is chronic and not related to the incident at hand. It is well documented that the patient has had a prior cervical surgery as well as a prior left rotator cuff repair, but there was no prior lumbar surgery. Either way, even though the patient had prior surgical procedures in the cervical area, the patient was completely asymptomatic and was able to function in all aspects of his life in private and as well as work without

any symptoms. All the symptoms overall were triggered once he was assaulted at work. goes also on to mention multiple physical findings that have nothing to do with this particular patient, leading us to believe that he is transposing information from another patient on to this case. Therefore, at this point, we will also submit for reconsideration on the hope that the next reviewing physician is able to not get confused on the information that is provided and realize that these diagnostic studies and procedures are indicated for this patient's pathology. The patient is also informed that the chiropractor where he is attending physical therapy has suggested a pain management physical therapy program. We suggested to the patient that this kind of treatment at this point is not indicated since he has not had a full diagnostic study in order to assess a more precise pathology and treatment option. Once he is fully diagnosed and treated, a work conditioning program or pain management physical therapy program might be helpful to him, but it is not indicated for him at this point.

09/07/12: UR performed. RATIONALE: This patient has three levels of the cervical spine already fused (C3-C4, C5-C6, and C6-C7) with now the C4-C5 showing degenerative changes and canal stenosis. The epidural steroid injection will not result in any canal decompression. There are allegedly left C5 nerve root symptoms and findings. The patient had a prior history of the neck fusion, which is likely contributing to the current C4-C5 symptoms. Thus, the request needs further validation as related.

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

The previous adverse decisions are overturned. After careful review of his records, which include an MRI scan of the cervical spine and physical examinations, it is my opinion that the claimant meets the requirements for epidural steroid injection of the cervical spine. According to ODG, radiculopathy must be documented, and his imaging studies corroborate these findings. He has had several examinations consistent with a C6 radiculopathy. He does have MRI evidence of spinal canal stenosis at the C5-C6 level. He meets the criteria for an epidural steroid injection of the cervical spine. Therefore, the request for 62310 Injection, W/WO Contrast; Diagnostic/Therapeutic, Cervical is medically necessary.

ODG:

Epidural steroid injection (ESI)	<p>Criteria for the use of Epidural steroid injections, therapeutic: <i>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.</i></p> <p>(1) Radiculopathy must be documented by physical examination <u>and</u> 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</p>
----------------------------------	---

	<p>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.</p> <p>(5) No more than two nerve root levels should be injected using transforaminal blocks.</p> <p>(6) No more than one interlaminar level should be injected at one session.</p> <p>(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.</p> <p>(8) Repeat injections should be based on continued objective documented pain and function response.</p> <p>(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.</p> <p>(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.</p> <p>(11) Cervical and lumbar epidural steroid injection should not be performed on the same day.</p> <p>Criteria for the use of Epidural steroid injections, diagnostic:</p> <p>To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:</p> <p>(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;</p> <p>(2) To help to determine pain generators when there is evidence of multi-level nerve root compression;</p> <p>(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;</p> <p>(4) To help to identify the origin of pain in patients who have had previous spinal surgery.</p>
--	---

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)**