MATUTECH, INC.

PO BOX 310069
NEW BRAUNFELS, TX 78131
PHONE: 800-929-9078
FAX: 800-570-9544

Notice of Independent Review Decision

Date: October 8, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Cervical epidural steroid injection C5-6

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME:

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

☒ Overturned (Disagree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Diagnostic (06/30/10)
- Office visits (07/29/10 - 08/13/12)
- medical evaluation (03/14/12)

- Diagnostics (01/21/08 - 04/11/12)
- Operative report (06/30/10)
- Office visits (12/14/10 – 06/07/12)

- Procedures (12/14/06 - 07/25/11)
- Diagnostics (06/11/07 - 01/21/08)
- Office visits (11/07/08 – 08/04/11)
- Utilization reviews (02/06/11, 02/08/11, 08/12/11, 08/30/11)

TDI

- Utilization reviews (06/20/12, 08/15/06)

ODG criteria was utilized for the denials

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was working and was attacked by bees on xx/xx/xx. He lost his footing and fell, landing directly on his right shoulder and entire right side of his body.

2006: Following the injury, the patient was seen at the emergency room (ER) where x-rays were obtained and he was treated with oral medications. Magnetic resonance imaging (MRI) of the left knee revealed low-grade medial collateral ligament (MCL) sprain and bipartite patella. MRI of the right shoulder revealed thinning of the supraspinatus tendon with articular surface fraying, intermediate signal articular surface tendinopathy of the subscapularis tendon and small subchondral cysts of the greater and lesser tuberosities.

noted complaints of pain in the neck, low back and right shoulder along with headaches. He diagnosed right shoulder/cervical spine/left knee/lumbar sprain/strain and referred the patient to an orthopedic surgeon.

On December 14, 2006, an orthopedic surgeon, performed right shoulder diagnostic arthroscopy with labral debridement, minimal debridement of the articular-sided partial rotator cuff tear and subacromial decompression and distal clavicle resection. The patient underwent postoperative therapy.

2007: On January 24, 2007, noted burning and popping in the anterior shoulder and recommended continuing therapy.

In February, noted no progress and recommended discontinuing therapy. In March, MRI of the cervical spine revealed 2 mm disc bulges from C3-C4 to C6-C7 with slight effacement of the thecal sac at all four levels. Electromyography/nerve conduction velocity (EMG/NCV) study of the right upper extremity was unremarkable.

In April, noted some subjective complaints of neck and lower back pain. He sent the patient for a second opinion and to a pain management physician.

In a psychological evaluation, the patient was diagnosed with pain disorder, anxiety, reactive depression and chronic pain condition. He was treated with individual psychotherapy sessions.

an orthopedic surgeon, noted neck, right shoulder, back and knee pain. He obtained MRI of the right shoulder which revealed full-thickness 5 x 6 mm tear of the supraspinatus at 11:00 position and 4 mm undersurface tear of the supraspinatus tendon at the 12:00 to 1:00 position. He recommended a repeat arthroscopy and epidural steroid injection (ESI) to the cervical and lumbar spine.

On May 16, 2007, performed a designated doctor evaluation (DDE). He opined that the patient was not at maximum medical improvement (MMI) as the problem was unresolved. He recommended a trial of cortisone injections and a second opinion, taking into consideration not only the arthrogram findings, but the inconsistencies in his presentation.

On May 24, 2007, performed diagnostic right shoulder subacromial decompression with debridement of partial rotator cuff tear and superolateral grade-1 tear separate glenohumeral compartment. The patient was started on therapy.

In June, MRI of the lumbar spine revealed mild distance fusion and a small focal central disc protrusion at L4-L5. noted ongoing pain in the lower back and recommended a lumbar ESI.

a pain management physician, performed cervical ESIs without any improvement. The patient complained of headaches and pain in the neck associated with numbness and tingling in the upper extremities.

In December, performed lumbar epidural blood patch for the treatment of spinal headaches.

2008 – 2010: A cervical discogram revealed grade II C3-C4 and grade III C4-C5, C5-C6 and C6-C7. recommended anterior cervical discectomy and fusion (ACDF) at C6-C7.

On March 6, 2008, performed a DDE and deferred assessment of MMI as the patient needed to undergo a neurosurgical evaluation involving his cervical spine.

In September 2008, psychiatrist/neurologist saw the patient for posttraumatic headaches, frequent lightheadedness, mild depression, and trouble falling and staying asleep. He placed the patient on Pristiq and Lidoderm 5% patches to be applied to the back.

On September 16, 2008, assessed MMI in regards to the shoulder, but stated the patient was not at MMI in regards to the cervical spine. He assigned whole person impairment (WPI) rating of 12%. He further opined that the Official Disability Guidelines (ODG) were improperly applied and surgery was medically necessary.

From September 2008, through February 2010, saw the patient for lumbar pain radiating down both legs with occasional tingling in the legs. Examination showed paresthesias extending to the lower extremities with straight leg raise (SLR) testing. X-rays of the lumbar spine showed bony alignment with no evidence of fracture or subluxation. assessed protrusion at L4-L5 with radiculitis and performed an epidural steroid injection (ESI) at L4-L5 on November 6, 2009. This was followed by post-injection therapy. stated that if the symptoms persisted, a lumbar discogram would be appropriate. But this was denied by the carrier.

On June 30, 2010, ACDF was performed at C6-C7. The diagnosis was discogenic neck pain at C6-C7. The surgery was followed by PT.

2011: On July 25, 2011, the patient underwent a medial branch block (MBB) at the left L4-L5 facet. noted significant improvement after the injection. However, the patient still had back pain that he rated as 6/10. Exam revealed positive Kemp's sign and back pain with SLR test. planned an outpatient radiofrequency rhizotomy at left L4-L5.

Per the letter dated July 25, 2011, had maintained the patient off work.

On August 4, 2011, noted the patient had occasional popping, but no significant pain. The patient had 5/10 pain mostly localized to the left side of the neck. He felt that the neck showed improvement after surgery. He complained of lumbar pain and had a previous epidural injection in November 2009. He still was experiencing approximately 50% improvement ever since the injection. recommended a radiofrequency rhizotomy at L4-L5 on the left.

On August 12, 2011, denied the request for outpatient radiofrequency rhizotomy.

On August 24, 2011, denied the appeal for outpatient radiofrequency rhizotomy at left L4-L5.

On September 20, 2011, independent review organization (IRO) upheld the denial for authorized the request for radiofrequency rhizotomy at L4-L5.

On September 29, 2011, reported the patient had good results with a recent medial branch block to his lumbar spine. He noted that the request for a radiofrequency ablation was denied by the insurance carrier. He opined that the patient had no ability to return to work in any capacity from July 28, 2011, until October 26, 2011, as a result of the injuries.

In December, noted that the contested case hearing was scheduled on December 5, 2011. The patient reported high levels of low back pain, discomfort with side-to-side movements, soreness and stiffness. opined that the patient's condition remained serious and he had no ability to return to work in any capacity from October 27, 2011, through January 25, 2012, as a result of the injuries.

2012: On January 5, 2012, noted that the patient had ongoing occasional pain which radiated down to his lower extremities. Examination of the lumbar spine showed tenderness, limited ROM, positive Kemp's sign on the left, and back pain on straight leg raise (SLR). He had 2+ reflexes in his patellae and 2+ in Achilles. X-rays of the cervical spine showed no bony abnormalities, no fracture and no subluxation. There was fusion present at C6-C7 in good position and alignment. assessed facet syndrome at left L4-L5, status post ACDF and shoulder arthroscopy. He renewed medications and recommended proceeding with a

radiofrequency rhizotomy at left L4 and L5 once authorized by the insurance carrier.

On March 14, 2012, performed a medical evaluation and rendered the following opinions: (1) Continued use of opioid medication such as Lorcet would be appropriate and a pain contract would be mandatory and all tenets therein should be followed including urine drug screen. (2) Use of Soma was totally inappropriate and it should be weaned. (3) Because of the uncertainty of the cervical fusion and the patient's continued pain, a computerized tomography (CT) myelogram would be appropriate. (4) A repeat MRI of the right shoulder would be indicated as well. (5) The patient fit the criteria of a facet syndrome. He had responded to diagnostic facet injection. While it was somewhat controversial, facet rhizotomy might be indicated for this patient. (6) For the sake of completeness, a follow-up MRI of the left knee might be an option.

In April, the patient reported constant pain in the back area and neck, discomfort with side-to-side movement, soreness and stiffness. He had ongoing pain into his bilateral upper extremities. Examination of the lumbar spine showed tenderness, limited ROM, positive Kemp sign on the left, and back pain on straight leg raise (SLR). He had 2+ reflexes in his patellae and 2+ in Achilles. Examination of the cervical spine showed tenderness on his right and left posterior cervical region with decreased ROM on flexion and extension and positive axial compression test. He had decreased strength in the upper extremities and some paresthesias in his hands bilaterally. assessed facet syndrome of the left L4 and L5, persistent pain status post ACDF and status post shoulder arthroscopy, improved. He recommended proceeding with a radiofrequency rhizotomy at the left L4 and L5 once authorized by the insurance carrier and MRI of the cervical spine.

On April 11, 2012, MRI of the cervical spine showed the following findings: (1) At C5-C6, mild interspace narrowing, 2-mm concentric posterior annular bulge with minimal foraminal encroachment on the right. This combined with uncinate hypertrophy produced mild foraminal encroachment on the left. (2) At C6-C7, interbody fusion graft producing paramagnetic artifact partially obscuring evaluation. Canal and foramina appeared patent. (3) Cervical lordosis was maintained.

On May 16, 2012, performed lumbar medial branch radiofrequency ablation at L4, L5 and S1 on the left for lumbar facet strain/syndrome.

On June 7, 2012, noted that the patient had neck pain and back pain with discomfort on side-to-side movements, soreness and stiffness. The patient had pain into his upper extremities with numbness and tingling. He also had occasional hip pain. reviewed the MRI findings. He assessed status post radiofrequency ablation at left L4 and L5, persistent pain status post ACDF with radiculitis and improved status post shoulder arthroscopy. opined that the patient had exhausted PT and oral anti-inflammatories with temporary relief. He renewed the medications and recommended continuing monitoring the patient's progress

following his radiofrequency ablation. He also recommended a cervical ESI in conjunction with post-injection therapy.

Per utilization review dated July 2, 2012, the request for a cervical ESI at C5-C6 was denied with the following rationale: *"There does not appear to be clinical findings on physical examination consistent with an objective focal neurological deficit in a dermatomal or myotomal pattern that would cause concern for neural compromise or radiculopathy stemming from the cervical spine. Weakness in the lower extremities would not constitute cervical radiculopathy. In the absence of radiculopathy, the patient would not be considered an appropriate candidate for this type of interventional pain management procedure."*

On July 26, 2012, opined that the patient was unable to work in any capacity because of the effects and conditions which resulted from the patient's work-related injuries and these effects and conditions included pain, ROM deficit, loss of sensation and recovery from other medical procedures. The patient was at risk for injury to himself and to others at work. He continued to remain symptomatic. also opined that the patient was unable to return to work from June 26, 2012, through October 24, 2012.

On August 1, 2012, ordered a cervical ESI.

Per reconsideration review dated August 7, 2012, the request for a cervical ESI at C5-C6 was denied with the following rationale: *"Based on the Official Disability Guidelines criteria, the role of the proposed treatment cervical ESI C5-C6 cannot be supported. The Official Disability Guidelines clearly indicate that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic findings. In this case, the claimant is with no clear true understanding of a radicular process that correlates to the C5-C6 level. In this case, the claimant is noted to be with no true understanding of a neurocompressive process at the C5-C6 level. Based on the above, the role of the C5-C6 epidural steroid injection cannot be deemed medically necessary.*"

On August 9, 2012, opined that the patient's disc derangement at C5-C6 was causing the upper extremity symptoms that included numbness, tingling and weakness, which were documented on physical examination. The patient met the criteria as outlined by the ODG to proceed with the recommended cervical ESI. resubmitted the request for cervical ESI and recommended proceeding with the procedure once authorized by the insurance carrier.
On August 13, 2012, the patient reported neck pain and constant back pain with discomfort on side-to-side movements, soreness and stiffness. The patient had pain into his bilateral lower extremities. He reported increase in numbness, tingling and weakness, and difficulty walking. Examination of the lumbar spine showed severe tenderness with decreased ROM in all directions and bilateral leg pain and back pain elicited on SLR. He had weakened muscle strength in knee flexors and knee extensors as well as extensor hallucis longus (EHL). He had paresthesias in the lateral aspects of the lower extremities into his heels. Examination of the cervical spine showed tenderness with decreased ROM in all

directions and positive axial compression test. The patient continued to experience a mildly positive Spurling's sign reproducing symptoms in his left upper extremity. His motor strength was weakened in wrist extension as well as grips. He also had some paresthesias on his forearm and first digit of his left hand. The patient was using a walking cane for ambulation. assessed status post radiofrequency ablation at left L4 and L5, persistent pain status post ACDF with radiculitis and improved status post shoulder arthroscopy. He renewed the medications and opined that the patient would benefit from cervical ESI in conjunction with post-injection PT. He recommended obtaining MRI of the lumbar spine with and without contrast.

Per the utilization review dated August 31, 2012, the request for MRI of the lumbar spine with and without contrast was non-certified based on the following rationale: ***"****The medical records did not demonstrate that the patient has met any of the criteria for which an MRI is indicated, per the guidelines below. It is acknowledged that the patient demonstrates clinical findings of radiculopathy with objective myotomal and dermatomal neurological deficits. However, the medical records did not clearly demonstrate that the patient recently failed a course of conservative therapy to the lumbar spine for a period of at least one month. Without evidence of red flags such as fracture, cancer, infection, cauda equina syndrome or myelopathy, the requested MRI is not warranted without first completing a recent course of conservative therapy with observation and failure. Given that this has not occurred, the requested MRI is not warranted at this time."*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The request for C5/6 is medically necessary. MRI of the cervical spine showed the following findings: (1) At C5-C6, mild interspace narrowing, 2-mm concentric posterior annular bulge with minimal foraminal encroachment on the right. The medical records document the symptoms and physical examination (positive Spurling's sign, muscle weakness and neurologic signs/symptoms) necessary for the diagnosis of a cervical radiculopathy. The patient has completed conservative treatment.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**