



Notice of Independent Review Decision - WC

IRO REVIEWER REPORT – WC

DATE OF REVIEW: 12/21/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical Epidural Steroid Injection at C7-T1 under Fluoro IV Sedation 62310 77003

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

Board Certified in Physical Medicine & Rehabilitation

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.

Cervical Epidural Steroid Injection at C7-T1 under Fluoro IV Sedation 62310 77003 – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Follow Up Appointment, 05/11/12
- Left Shoulder MRI, 05/31/12
- Initial Pain Evaluation, 06/28/12
- Follow Up Notes, 07/16/12, 08/16/12, 09/13/12, 10/08/12, 11/26/12
- Denial Letters, 10/25/12, 11/15/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The date of injury is listed as xx/xx/xx. On that date, the patient developed difficulty with pain in the left shoulder and into the left hand when the claimant performed a lifting activity in the workplace.

A left shoulder MRI scan accomplished on 05/31/12 disclosed findings consistent with an intact rotator cuff. There was evidence for osteoarthritis in the acromioclavicular joint. There was evidence for an ill-defined signal alteration in the superior labrum after a prior labral repair, which was felt to possibly reflect postoperative change.

The patient was evaluated on 06/28/12. It was documented that the patient was approximately two and one-half years removed from undergoing surgical intervention to the left shoulder. On physical examination, there was documentation of allodynia in the left upper extremity. He was diagnosed with a post-traumatic sprain of the left shoulder, a myofascial pain syndrome, and also it was documented that there was a concern that he could be with a complex regional pain syndrome referable to the left upper extremity. The patient was provided a prescription for Neurontin. He was also provided a prescription for Vicodin. It was also recommended that consideration be given for treatment in the form of a diagnostic/therapeutic stellate ganglion blockade and/or treatment in the form of a cervical epidural blockade.

re-evaluated the patient on 07/16/12. On this date, there were symptoms of pain referable to the left shoulder. It was recommended that he receive access to treatment in the form of trigger point injections.

On 08/16/12, evaluated the patient. On this date, it was documented that he was “not showing any signs of radiculopathy.” It was recommended that he receive access to treatment in the form of trigger point injections. It was documented that there was no evidence of pseudomotor or vasomotor changes.

evaluated the patient on 09/13/12. It was documented that he was a participant in full duty work activities. It was recommended that he receive access to treatment in the form of stellate ganglion blockade.

On 10/08/12, assessed the patient who was documented that treatment in the form of stellate ganglion blockade was not authorized. As a result, it was recommended that he receive access to treatment in the form of a cervical epidural blockade.

assessed the patient on 11/26/12. On this date, it was documented that he was with symptoms of pain referable to the left upper extremity. It was recommended that he receive access to treatment in the form of a cervical epidural blockade.

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

The date of injury is listed as xx/xx/xx. The records available for review indicate that there are symptoms of pain that radiate throughout the left upper extremity. The records

available for review do not indicate that a cervical MRI scan has been accomplished to determine if there is a compressive lesion upon any of the neural elements in the cervical spine that could be responsible for the documented symptoms. A left shoulder MRI scan accomplished after the date of injury did not reveal the presence of any findings worrisome for a tear in the rotator cuff musculature. The records available for review indicate that there is a concern that the patient could be with a complex regional pain syndrome referable to the left upper extremity. Based on the records available for review, the Official Disability Guidelines would not support the medical necessity for a cervical epidural steroid injection as a diagnostic/therapeutic measure for the medical condition of a complex regional pain syndrome referable to the left upper extremity. Such a procedure is not typically considered a first line procedure for medical treatment of the described medical situation. Additionally, there does not appear to be documentation of consistent radicular symptoms to support a medical necessity for a cervical epidural steroid injection. The medical documentation of 08/16/12 specifically indicated that there were no signs of a cervical radiculopathy. As such, in this particular case, per strict criteria set forth by the Official Disability Guidelines, the medical necessity for treatment in the form of a cervical epidural steroid injection with sedation is not established per the criteria set forth by the Official Disability Guidelines.

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

- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**