



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 7/25/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of cervical ESI, epidurography, radiology, and anesthesia.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and 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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of cervical ESI, epidurography, radiology, and anesthesia.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records were received and reviewed from the following parties: Review, Interstate

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Review:

Review:

Utilization Review Worksheets – 6/7/13, 6/11/13, 6/21/13

Adverse Determination Letters – 6/11/13, 6/21/13

Phone Call Note – 6/10/13

Pre-Authorization Requests – 6/7/13, 6/11/13

Established Patient Encounter Note – 6/6/13

MRI of the Cervical Spine w/ Contrast – 10/31/12

Peer Review – 1/22/13

DDE Report – 3/19/13

DWC69 – 3/19/13

Medical Necessity Review – undated

Records reviewed from Interstate:

Musculoskeletal Evaluation – 6/26/13

Notice of Disputed Issue and Refusal to Pay Benefits – 2/20/13

Initial Medical Report – 10/15/12

Office Note – 7/19/12-12/7/12

Muscle Test – 10/17/12, 11/19/12, 1/2/13, 6/26/13

Employers First Report of Injury or Illness – xx/xx/xx, xx/xx/xx, xx/xx/xx, xx/xx/xx,
Xx/xx/xx, xx/xx/xx

Medical Report – 10/9/85-5/30/89

Physician's Final Report & Bill – 10/18/85

Lumbar CT – 7/21/89

Notice of Injury or Occupational Disease and Claim for Compensation – 9/25/89,
1/14/92, 6/20/94, 11/13/94, 4/18/00, 11/17/00, 11/15/02, 9/8/06,
6/30/10

Operative Report – 6/6/90

Follow-up Note – 10/6/90-12/11/90

WC Medical Report – 1/16/91

Lumbosacral Spine Series – 11/15/90

Return to Work Certificate – 1/20/92, 9/17/92, 11/23/92

Narrative History - undated

Return to Work – 4/10/92, 6/2/92

Restrictions Report – 8/10/92

DWC69 – 6/15/92, 7/22/94, 3/25/07, 10/26/10

Employer's Supplemental Report of Injury – 6/19/92, 9/17/92

Off Work Script – 9/4/92, 11/18/92

Initial Medical Report – 6/1/93, 11/4/94

Prescription Receipt – 6/1/93

Initial Office visit – 3/17/95

Follow-up Office Visit – 4/21/95-11/6/95

Employee's Request to Change Treating Doctors – 4/21/95

DWC69 – 11/6/95, 1/22/96, 4/26/00, 1/31/01, 5/1/02, 11/7/08, 11/9/08

DDE Report – 1/22/96

Initial Clinic Visit – 6/9/00

Clinic Visit – 8/10/99, 1/5/01, 7/20/01, 3/5/02, 6/13/03, 3/26/04, 5/11/04,
9/7/04, 2/15/05

Letter of Medical Necessity – 2/19/02

DDE Report – 5/3/02

Chart Note – 5/28/04

Independent Medical Evaluation Report – 4/26/00

Operative Report – 6/5/00, 7/24/00

Lumbar Myelogram report – 6/5/00

Post Myelogram CT of the Cervical Spine – 6/5/00

CT Scan Lumbar Spine Post discogram – 7/24/00

Lumbar Discogram – 7/24/00

RME Report – 1/26/01

Office Note – 6/19/01

Work Restrictions - undated

MR C Spine without Contrast – 8/30/01

DWC73 – Various dates

IME Report – 4/5/01

Exam Report – 6/28/04

RME Report – 5/31/05

FCE – undated

TWCC Second Opinion – 3/18/02

Impairment Evaluation 4th Edition – 5/1/02

Exam Report – 6/12/03

EMG and Nerve Conduction Study – 4/21/04

Evaluation Letter – 7/3/04

RME – 7/6/04

New Patient Evaluation – 4/22/08

Office Visit Note – 6/3/08, 8/5/08, 9/2/08, 10/14/08, 11/11/08, 1/13/09,
1/12/01, 8/31/10, 1/11/11, 2/22/11, 7/12/11, 1/10/12, 7/10/12

MMI Disagreement Letter – 6/2/08

Operative Report – 7/28/08

DDE Report – 9/10/08, 11/7/08

DDE Report – 10/26/10

Workers' Comp – First Report of Injury or Illness – xx/xx/xx

Office Note – 10/9/12, 10/15/12

Employee's Claim for Compensation for a Work-Related Injury – 10/13/12

Utilization Review Determination – 10/18/12, 11/30/12, 12/11/12

STIM Unit Request – 11/13/12

New Patient Encounter – 11/29/12

Established Patient Encounter – 1/21/13, 4/8/13, 6/6/13

Department of Insurance Statement of Pharmacy Services – 12/7/12

Procedure Note - 3/22/13, 5/17/13

Medical Timeline – 10/8/85-6/26/13

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This worker has a history of Worker's Comp injuries dating back to xx/xx/xx when he slipped and injured his lower back. According to available medical records, his first cervical problems were reported on xx/xx/xx when the patient states that he felt a "pop" in his neck while in physical therapy. He had immediate right-sided neck and shoulder pain. Subsequently, the injured worker was treated for neck and bilateral shoulder problems. On xx/xx/xx, he had a reported injury to the neck. He was treated conservatively for this problem and ultimately underwent surgery on July 28, 2008 for an anterior cervical decompression and discectomy, foraminotomy bilaterally at C5-6 and C6-7, and fusion at C5-6 and C6-7. saw the patient on multiple occasions in follow-up and on September 2, 2008, reported that the neck and arm pain had resolved.

continued to follow the patient and on July 10, 2012, noted that the patient was complaining of numbness and tingling in his right first, second, and fourth digits and left second digit.

On xx/xx/xx, the worker was again injured. He was struck on the right side of the head and neck by a large tire. There was no loss of consciousness. Diagnoses of concussion and cervical strain were made. The injured worker was said to have decreased cervical range of motion and mild tenderness along the paraspinal muscles bilaterally. The neurologic exam was said to be normal. Cervical x-rays showed that the fixation device was in place without signs of loosening. The patient was treated with ibuprofen, Flexeril, and restricted duty. He was evaluated on October 15, 2012 and chiropractic therapy was recommended and initiated.

On October 31, 2012, an MRI of the cervical spine was performed. This showed evidence of a prior anterior cervical fusion from C5 to C7, moderate to severe bilateral neural foraminal narrowing at C3-4 and C7-T1, and moderate canal stenosis at C3-4 with a possible annular tear.

On November 19, 2012, the injured worker began a pain management program with noted the injury and stated that the patient was reporting neck pain and stiffness as well as cramps and weakness. Strength was reported as 5-/5 and deep tendon reflexes were reported as 1/4. Sensation was said to be intact. The patient was prescribed Flexeril, Lyrica, and Norco and transforaminal epidural steroid injections at C4-5 were recommended. These injections were denied because there was said to be no confirmatory evidence of nerve root impingement.

On January 22, 2013, a Peer Review was provided who stated that there was no medical necessity for epidural steroid injections since there was no objective evidence of acute cervical radiculopathy.

On March 19, 2013, performed a Designated Doctor Evaluation. He noted that the patient had had prior cervical problems. He stated that the injured worker had complaints of numbness in his hands, but this numbness was present prior to the injury and was unchanged following the injury of xx/xx. There was also said to be no new weakness. The identified problem was pain and stiffness in the cervical area. documented decreased cervical range of motion and decreased sensation to fine touch in the region of the right elbow and index finger, but normal strength. gave the opinion that the injured worker was not at maximum medical improvement and would benefit from further treatment which might include trigger point injections, therapy, and medical management.

On March 22, performed bilateral epidural steroid injections at the C4-5 level. On April 8, reported that the patient had had "sixty percent relief." He stated that the current pain level was 3/10. On May 17,

epidural steroid injections at the C4-5 level were repeated. On June 6, reported that there was eighty percent relief and that the pain level was still 3/10. documented decreased cervical range of motion, severe bilateral paraspinal tenderness, no atrophy, intact sensation in the upper extremities, a positive Spurling's sign, strength measuring 5-/5, and reflexes recorded at 1/4. requested a third epidural steroid injection which was denied on the basis of there having been insufficient time between injections.

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

This worker has had multiple work-related injuries, his latest being an injury to the head and neck on xx/xx/xx. He had had surgery on his cervical spine in 2008 and did well postoperatively. Since his xx/xx/xx injury, he has had multiple medications including muscle relaxers, Lyrica, and ibuprofen. He has also had chiropractic therapy. He had epidural steroid injections at the C4-5 level on March 22, 2013 and May 17, 2013.

This injured worker does not meet criteria for a third cervical epidural steroid injection. The ODG Treatment Guidelines indicate that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this individual, current radiculopathy is not clearly documented. physical examination indicated that there is a positive Spurling's sign, but there was no evidence of muscle atrophy, isolated muscular weakness, or reflex changes. There is no description of a radicular type pain into the shoulder girdle or upper extremity.

The American Medical Association's Guide to the Evaluation of Permanent Impairment, Fourth Edition indicates that differentiators used to document radiculopathy would include loss of reflexes, radicular complaints that follow anatomical pathways, decreased circumference or atrophy, and electrodiagnostic evidence of radiculopathy.

ODG Treatment Guidelines state that in the therapeutic phase, repeat blocks should only be offered if there is at least fifty percent pain relief for six to eight weeks with a general recommendation of no more than four blocks per region per year. According to available medical records, this injured worker received his first injection on March 22 and sixteen days later, was seen in follow-up with a statement that the patient had obtained "sixty percent relief" and his current pain was 3/10. This clearly is not a six to eight week time period. His second block was performed on May 17. Twenty days later, the evaluating physician stated that there had been eighty percent relief with a current pain level of 3/10. Neither of these blocks provided six to eight weeks of relief, at least according to available medical records. Furthermore, the ODG Guidelines do state that although there may be up to four blocks per region per year, the Guides clearly state that current research does not support a "series of three" injections in

either the diagnostic or therapeutic phase. The Guides recommend no more than two injections; therefore, the requested treatment is not medically necessary.

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)**
American Medical Association's Guide to the Evaluation of Permanent Impairment, Fourth Edition