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Notice of Independent Review Decision

DATE OF REVIEW: 8/7/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of right cervical epidural steroid injection at C4-5 and C5-6.

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/Rehab.

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 medical necessity of right cervical epidural steroid injection at C4-5 and C5-6.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, this worker was injured on xx/xx/xx. There is no indication in the record as to what body area was injured or how the injury occurred. The first record presented for review is dated January 9, 2014. This note is for a bilateral facet

injection at C3-4, C4-5, C5-6, and C6-7. clearly states in this operative note that the injured worker has “neck pain with absence of upper extremity radiculopathy.”

continued to follow the patient with documented visits on February 26, 2014, April 13, 2014, May 19, 2014, and June 6, 2014. During those visits, stated that the injured worker had neck and right shoulder pain at one point described as “severe, excruciating and intractable.” The patient was also said to have sympathetically maintained pain in the right upper extremity and shoulder. Physical examination findings reference “neck supple”, decreased range of motion, normal reflexes and sensation, upper extremity weakness, right shoulder weakness, and “numbness and weakness extending to the hand.”

The injured worker apparently had concurrent problems with the neck and right shoulder. He reportedly had surgery on the right shoulder on August 13, 2013 and a repeat surgical procedure on April 3, 2014. He was followed for shoulder problems provided pain management services to the injured worker and recommended epidural steroid injections as early as May 19, 2014. A Letter of Adverse Determination was provided on May 23, 2014 because there was no unequivocal description of radiculopathy on the physical examination and imaging studies. This decision was apparently appealed and a second Utilization Review finding was issued on July 7, again stating that there was no unequivocal evidence of objective findings to suggest utilization of C4-5 and C5-6 epidural steroid injections. This opinion was rendered.

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

Clinical Decision:

Recommend adverse determination since the medical record does not adequately support the prospective medical necessity of right cervical epidural steroid injection at C4-5 and C5-6.

V. Rationale or Basis for Decision:

According to this record, this worker was injured on xx/xx/xx. There is no description of the original injury or original treatment. He apparently had at least two surgical procedures on his right shoulder. There is also mention of cervical spine surgery in 2007 and 2009. As far as I can tell from available medical records, there was a laminectomy and decompression as well as posterior fusion at C5-6 on April 5, 2009. There is also a mention of an anterior cervical discectomy infusion at C5-6 on September 26, 2010. It is unclear as to what procedure if any was performed in xxxx.

The available medical record included a statement on January 9, 2014 that the injured worker had “neck pain with absence of upper extremity radiculopathy.” Later notes indicate that the individual had neck and right shoulder pain as well as sympathetically mediated pain in the right upper extremity. There are descriptions stating that the neck is “supple” although there are other descriptions of limited range of motion of the neck. There is no description of a Spurling’s sign and no objective description of the cervical range of motion. There is no

description of reflex change though the ODG Treatment Guidelines state that neurologic findings should be identified including reflexes of the biceps, triceps, and brachioradialis tendons. There should be a description of weakness or atrophy of muscle groups of the arm. Although there are statements that there is weakness in the right shoulder and arm, there is no clear description of which muscle groups are weak and there is no evidence in the medical record of atrophy. There is also mention of sensory loss, but no clear description of dermatomal sensory loss.

Apparently, no EMG has been performed. There is a note in the chart that MRI studies showed herniation at C5-6 and C4-5 though that report was not available in the medical record. There is also a statement in one of the Utilization Review Letters that the cervical spine showed mild disk protrusions at several vertebral levels, and osteophyte and spur projection into the right neural foramen at C5-6 resulting in mild to moderate neural foraminal stenosis.

ODG Treatment Guidelines state that in order to justify cervical epidural steroid injections, there should be clear objective evidence of radiculopathy. This record does not clearly indicate that the injured worker has a radiculopathy. Imaging studies are suggestive of the possibility of a radicular problem, but in the absence of clear objective physical findings and/or electrodiagnostic testing, the medical necessity for epidural steroid injections at C4-5 and C5-6 cannot be established.

VI. Reference:

ODG Treatment Guidelines

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)