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November 23, 2015:

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical ESI under monitored anesthesia

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX-year-old male who was injured on XX/XX/XX. The patient was digging a cement hole on-the-job and strained his neck and back.

On September 16, 2013, MRI of the cervical spine showed severe neural foraminal narrowing on the left at C2-C3, C5-C6 and on the right at C3-C4, moderate neural foraminal narrowing on the right at C2-C3, C4-C5 and on the left at C3-C4. Moderate canal stenosis was seen at C3-C4, C4-C5 and C5-C6.

On September 16, 2013, MRI of the lumbar spine demonstrated mild bilateral neural foraminal narrowing at L3-L4 and L4-L5.

On January 29, 2014, evaluated the patient for neck pain and low back pain rated as 4/10. The patient was utilizing methocarbamol, methylprednisolone and meloxicam. The patient had been

having a neck brace for the last five to six months. The patient also had five to six sessions of pt. He reported numbness and tingling in the right upper extremity. MRI of the lumbar and cervical spine was reviewed. diagnosed neck and lumbar sprain/strain, brachial neuritis or radiculitis, cervical spondylosis without myelopathy, cervical disc displacement and spasm of muscle. The patient was scheduled for an epidural steroid injection (ESI).

On February 17, 2014, cervical myelogram showed asymmetric nerve root filling of the right C6 nerve root and mild indentation on ventral cervical arachnoid space at multiple levels, most prominent at C3-C4. Post-myelogram CT scan cervical spine showed the right C6 nerve root to be enlarged as it exited the thecal sac with mild narrowing of the central canal at C5-C6 and minimal narrowing of right C6 foramen. There was mild narrowing of the central canal at C3-C4 with mild right C4 foraminal stenosis.

On March 5, 2014, Cervical ESI was performed at the C7-T1 level.

On September 23, 2014, noted the patient had very little relief with the cervical ESI. He complained of moderate-to-severe right side neck and low back pain. The pain was described as sharp and stabbing. The patient was taking hydrocodone and meloxicam with no side effects. He informed he was needing electromyography (EMG) before performing surgery.

On October 14, 2014 performed a required medical evaluation (RME) and rendered the following opinions: The compensable body parts/conditions were cervical spondylosis, cervical intervertebral disc disorder, lumbar sprain/strain, sprain/strain of upper and lower extremity and left hand sprain/strain. The patient had not reached maximum medical improvement (MMI) per the ODG. An EMG/NCV of the upper extremities as well as comprehensive neuropsychological evaluation should be obtained prior to any consideration of cervical decompressive surgery. The patient was currently unable to return to work.

On October 27, 2014, electrodiagnostic studies were performed. The study revealed electrophysiological evidence of bilateral moderate median nerve lesions at the wrists compatible with bilateral carpal tunnel syndrome (CTS). There was also evidence of bilateral C5-C6 radiculopathy.

On November 20, 2014, noted the patient had continued cervical radiculopathy in the bilateral upper extremities due to disc herniation. XX refilled gabapentin, meloxicam, methocarbamol and increased the dose of hydrocodone.

On December 18, 2014, noted the increase in HC had helped the patient; however, he was still not able to sit or stand for more than an hour. The patient was asking for a pass from his electronic school, as he could not tolerate the positions. Medications were refilled and urine drug screen (UDS) was ordered.

On January 14, 2015, noted the patient complained of moderate low back pain that was being managed with medication. He had increased pain due to cold wet weather. The patient was ambulating with a single point cane. Meloxicam was refilled. A UDS was obtained and was inconsistent for medication.

saw the patient on February 12, 2015. The patient was given refills of hydrocodone, gabapentin, meloxicam and methocarbamol.

On March 24, 2015, the patient had monthly follow-ups. It was noted the patient had undergone cervical surgery on February 25, 2015, and was now in a C-collar. He stated he was having some difficulty swallowing and had pain to the bilateral shoulders. Hydrocodone, gabapentin, meloxicam and methocarbamol were refilled.

On April 22, 2015, and May 22, 2015, the patient reported some numbness to the incision site and to the left side of his mouth. He stated sometimes he drooled when eating. He had also fallen on XX/XX/XX, and feeling pain to the cervical spine and falling on his elbow and right wrist. asked him to decrease his gabapentin to see if it lessened his headaches.

On Jun 26, 2015 x-rays cervical spine showed an anterior fixation device attached to C5 and C6 and interspace devices in place.

On July 2, 2015, the patient reported numbness to the incision site, left upper pectoral region and to left side of his moth. refilled medications.

On July 31, 2015, the patient complained of moderate-to-severe neck and bilateral shoulder and elbow pain. refilled medications and ordered x-rays of the cervical spine.

On September 2, 2015, the patient complained of neck pain radiating to the right arm. He was managing with Norco, gabapentin and Mobic. VAS was 7/10. Spouse stated the patient was getting depressed. On exam, ROM was severely decreased. ordered a cervical ESI as well as bilateral shoulder injections.

On September 10, 2015, Utilization review denied the request for cervical ESI under monitored anesthesia. Rationale: *“Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Clarification is needed regarding the specific level of the required injection. Nonetheless, ODG does not recommend cervical ESI’s based on recent evidence, given the serious risks of this procedure to the cervical region, and the lack of quality evidence for sustained benefit. In addition, there was no evidence of failure of recent conservative care including active therapy and pain medications supporting the use of injections for pain management. Notably, .clinical benefit specifically derived from his current regimen was not documented in the submitted records, and there was no evidence that the patient has attended postoperative PT to address his current neck complaints. Lastly, there was no evidence that the patient is diagnosed with severe anxiety supporting the use of monitored anesthesia during procedure.”*

On September 24, 2015, Appeal letter was submitted for the denied procedure.

On October 2, 2015, noted no changes in the patient’s condition. Medications were refilled and PT was ordered for the cervical spine for ROM/flexibility enhancement, strengthening and deconditioning.

On October 22, 2015 per utilization review, the appeal for cervical ESI under monitored anesthesia was non-certified. Rationale: *“Based on the clinical information submitted for this review and using the evidence based peer-reviewed guidelines referenced above, this request is non-certified. Given the lack of any new trauma or changes in the symptoms or the development of new pathology, the request is not indicated.”*

On October 29, 2015, noted the patient complained of moderate-to-severe neck and low back pain. The patient was taking Norco and gabapentin. The patient had been seen by XX on October 8, 2015, and was given an IR of 19%. XX provided refills of medications and recommended approval of the cervical ESI.

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

Patient with EMG evidence of radiculopathy with chronic pain who has failed prior conservative care.

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

x ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES