



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**Date notice sent to all parties:** 4/15/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

The item in dispute is the prospective medical necessity of a C6-7 ESI.

**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 Orthopedic Surgery.

**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 disagrees with the previous adverse determination regarding the prospective medical necessity of a C6-7 ESI.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

According to available medical records, this worker was injured on xx/xx/xx when the truck he was driving was struck and turned over multiple times. He sustained a head injury with an intracerebral hemorrhage as well as cervical injury and an injury to his back.

There are no records regarding early treatment of the patient. MRI studies of the cervical spine performed on July 19, 2013 showed minimal disk bulges at C4-5 and C5-6, a mild diffuse disk bulge at C6-7 causing mild central canal stenosis and minimal bilateral neural foraminal stenosis at C6-7. Electrodiagnostic studies performed on October 30, 2013 were said to show EMG changes consistent with a left ulnar neuropathy and slowing of ulnar nerve conduction velocity around the left elbow with decreased amplitude of the left ulnar sensory nerve action potential. There was no EMG evidence of a significant cervical radiculopathy reported from that study.

On November 10, 2013, the injured worker began treatment. noted the injury and complaints of back pain, neck pain, bilateral arm pain, and bilateral leg pain. Upper extremity reflexes were said to be active and symmetrical. Strength in the left upper extremity was said to be reduced at 4/5 following recent left elbow surgery. Sensation was reported to be intact to light touch over both upper extremities. Spurling's sign and Lhermitte's sign were said to be negative. Cervical spine x-rays were reported to be normal.

recommended six to eight weeks of physical therapy, a Medrol Dosepak, non-steroidal anti-inflammatory medications, muscle relaxers, pain medications, neuromuscular stimulation, transdermal pain cream, and an epidural steroid injection. The injured worker continued to report neck pain radiating into the left arm. requested repeat electrodiagnostic studies to document the presence of radiculopathy, but these requests were denied. Multiple requests for epidural steroid injections were also placed, but denied. The injured worker underwent a Functional Capacity Evaluation on October 22, 2014 and began a comprehensive pain management program which ended following 240 hours of treatment in mid-January.

On January 15, noted that the injured worker was continuing to complain of pain which had not improved. Atrophy of the triceps muscle was described as well as 3/5 weakness in the deltoid, triceps, wrist extensors, wrist flexors, and hand intrinsics, in the left upper extremity. again recommended EMG to document radiculopathy and epidural steroid injection to treat the herniation of the cervical disk at the C6-7 level.

On February 13, 2015 documented that the injured worker's pain had increased. He was complaining of shooting pain that radiated from his neck down the left upper extremity to the hand with constant numbness in the posterior aspect of the hand and second and third digits. Deep tendon reflexes were said to be normal. There was said to be 3/5 strength in the triceps and 4/5 strength in the wrist flexors and grip. Again, EMG and epidural steroid injections were requested.

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

The ODG state that for epidural steroid injections to be used for the purpose of therapy, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The most recent examination on this injured worker indicates that his deep tendon reflexes were normal, but there were sensory changes in the second and third digits of the left hand and evidence of triceps atrophy and weakness in the triceps and distal muscle groups. The EMG study that was performed was performed in 2013 and did not show signs of radiculopathy. MRI studies did show a mild disk

bulge with some bilateral neural foraminal stenosis at the C6-7 level. The injured worker has not reported resolution of his symptoms with conservative treatment including physical therapy, an extensive pain management program, multiple medications, a neuromuscular stimulator, and transdermal pain creams.

There are continued symptoms consistent with radicular pain and documented physical findings which are suggestive, but not conclusive, of radiculopathy, specifically triceps atrophy which is actually not quantified and weakness and sensory changes in the 2nd and 3rd digits of the hand. Reflex changes have not been documented. Imaging studies have shown suggestive cause for symptoms including a moderate disk bulge at C6-7 causing mild central canal stenosis and minimal bilateral foraminal stenosis. These findings, however, are not in and of themselves conclusive evidence of radiculopathy. Since the EMG performed on October 30, 2013 (which did not show signs of radiculopathy), the injured worker has developed actual triceps atrophy and weakness as well as sensory deficits which do not fit in the distribution of the ulnar nerve lesion described in the October, 2013 EMG, but do fit in a dermatomal distribution. Therefore, I would conclude that this injured worker's physical findings have changed and would be more consistent with radiculopathy.

Repeat electrodiagnostic studies have been denied. The ODG does state that diagnostic epidural steroid injections can be performed to determine pain generators when clinical findings are suggestive of radiculopathy and imaging studies have suggested cause for symptoms but are inconclusive. I would conclude that a diagnostic epidural steroid injection at the C6-7 level would be consistent with ODG Treatment Guidelines and is therefore 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)**