



CompPartners Final Report



CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name: _____
Texas IRO # : _____
MDR #: M2-06-1165-01
Social Security #: _____
Treating Provider: James Marvel, MD
Review: Chart
State: TX
Date Completed: 5/22/06

Review Data:

- **Notification of IRO Assignment dated 4/25/06, 1 page.**
- **Receipt of Request dated 4/25/06, 1 page.**
- **Medical Dispute Resolution Request/Response dated 4/7/06, 1 page.**
- **List of Treating Providers (date unspecified), 1 page.**
- **Table of Disputed Services (date unspecified), 1 page.**
- **Notice of Intent to Issue an Adverse Determination dated 3/10/06, 1 page.**
- **Notice of Utilization Review Findings dated 3/16/06, 3/13/06, 4 pages.**
- **Daily Notes dated 2/2/06, 12/28/05, 11/23/05, 10/24/05, 9/27/05, 9/20/05, 9/7/05, 8/24/05, 3 pages.**
- **Office Visit dated 3/31/06, 2/28/06, 2/7/06, 9/15/05, 7 pages.**
- **Procedure Note dated 2/16/06, 1 page.**
- **New Patient Evaluation dated 1/13/06, 3 pages.**
- **Consultation and Electrodiagnostic Studies dated 11/15/05, 5 pages.**
- **History and Physical (date unspecified), 2 pages.**
- **Cervical Spine MRI dated 8/30/05, 1 page.**
- **Assessment and Progress Record dated 9/27/05, 1 page.**
- **Plan of Care (date unspecified), 1 page.**
- **Fax Cover Sheet dated 4/27/06, 1 page.**
- **Pre-Authorization Request dated 3/7/06, 1 page.**
- **Post Injection Evaluation dated 1/31/06, 1 page.**
- **Legal Letters dated 5/2/06, 4/14/06, 4 pages.**

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied request for C6-7 epidural steroid injection.

Determination: **UPHELD** - the previously denied request for C6-7 epidural steroid injection.

Rationale:

Patient's age: 40 years
Gender: Male
Date of Injury: _____

Mechanism of Injury: Fell off a ladder, landed on right elbow/right shoulder.

Diagnoses:

1. C6-C7 disk protrusion with associated right upper extremity numbness and tingling.
2. Right carpal tunnel syndrome.

Subsequent to this injury, the patient underwent a cervical MRI on August 30, 2005, which revealed a protrusion at the C6-7 level posterocentrally and posterolaterally on the left, considered to be a herniated disk. Reportedly, the patient underwent conservative treatment consisting of four weeks of physical therapy and medication management. Subjective complaints consisted of neck pain graded on a visual analog scale (VAS) of 5/10 described as sharp, dull, and burning, with aching spasms and associated with electrical pains (numbness and tingling) in the right upper extremity. Electrodiagnostic studies (EMG/NCV) performed on November 15, 2005, revealed no evidence of radiculopathy or brachial plexus problems, and no evidence for generalized neuropathy; significant right carpal tunnel syndrome was present. This claimant reportedly had a neurosurgeon evaluation performed sometime in December 2005, but the report was not submitted for review. On January 13, 2006, the patient was referred to Kenneth Kemp, M.D. His objective findings included negative neural tension testing in the upper extremities, and negative Spurling's maneuver for radicular pain. However, it did cause some pain into the outer part of the patient's right shoulder, no tenderness to palpation over the rotator cuff or bicipital tendon, tenderness in the right middle trapezius muscle and cervical paraspinal muscles, and negative impingement testing bilaterally. Cervical spine examination revealed tenderness to palpation over the midline of the cervical spine and right cervical facets, greater than left at C5-6 and C6-7 levels. Neurologic examination revealed intact motor, sensory, and reflex testing, with mild increasing sensation in the right C6 distribution. At this time, the patient was diagnosed with right C6 radiculitis, and right C6-7 interlaminar epidural steroid injection was proposed. This procedure was performed a few weeks later, which resulted in significant relief from stiffness and problems in the neck, but continued with the pain in the right arm, rated at a VAS score of 6/10. The claimant also had pain in the right shoulder, aggravated with lifting his arm. Medication management at that time, included Cymbalta. The decision was not to perform a second cervical epidural steroid injection, but instead, proceed with a right shoulder joint injection. This procedure was performed on February 16, 2006, which resulted in "no real relief." It is the opinion of the reviewing physician that, based upon the submitted medical records reviewed, the original decision of non-authorization for C6-7 epidural steroid injection be upheld because:

1. Lack of available relevant clinical information in support of the application, particularly no information regarding the presence of significant objective radiculopathies (i.e. absence of sensory, motor, or reflex deficits in the upper extremities). In the follow-up note submitted, although, the patient seems to have subjective symptoms suggestive of radiculitis.
2. The lack of improvement following the first cervical epidural steroid injection involving the patient's subjective right upper extremity radiculitis pain.
3. The radiographic imaging study report of cervical MRI revealed a disk protrusion at the C6-7 level, with no evidence of significant spinal canal stenosis, neural foraminal stenosis, or nerve compression.

Therefore, the request submitted does not meet the criteria for consideration of cervical epidural steroid injection as per the current acceptable standard of pain management practice.

Criteria/Guidelines utilized: The ACOEM Guidelines, 2nd Edition, Chapter 8.

Interventional Pain Management, 2nd Edition, edited by Dr. Steven D. Waldman in Chapter 31, entitled “Cervical Epidural Nerve Block”, pages 373 to 381.

Physician Reviewers Specialty: Pain Management

Physician Reviewers Qualifications: Texas Licensed M.D. and is also currently listed on the TDI/DWC ADL list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee’s employer, the injured employee’s insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.

Your Right to Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code § 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers’ Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, Second Edition.
Chapter 8-Neck and upper back, Pg 173-175

Initial Care

Comfort is often a patient’s first concern. Nonprescription analgesics will provide sufficient pain relief for most patients with acute and subacute symptoms. If treatment response is inadequate (i.e., if symptoms and activity limitations continue), prescribed pharmaceuticals or physical methods can be added. Comorbid conditions, side effects, cost, and provider and patient preferences generally guide the clinician’s choice of recommendations. [Table 8-5](#) summarizes comfort options.

- Manipulation has been compared to various treatments, but not placebo or nontreatment, for patients with neck pain in nearly twenty randomized clinical trials. More than half favored manipulation, with one reporting better results in combination with exercise, while the remainder indicated treatments were equivocal. Cervical manipulation has not yet been studied in workers’ compensation populations. In rare instances (estimated at 1.0-1.5 per million manipulations), manipulation has been associated with cerebrovascular accident. Some studies suggest that this risk is based on the position of the patient, not the act of manipulation itself. Serious side effects are extremely rare and far less frequent than those associated

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with commonly prescribed alternatives such as nonsteroidal anti-inflammatory drugs (NSAIDs), but the issue is currently under study and should be monitored.

Using cervical manipulation may be an option for patients with occupationally related neck pain or cervicogenic headache. Consistent with application of any passive manual approach in injury care, it is reasonable to incorporate it within the context of functional restoration rather than for pain control alone. There is insufficient evidence to support manipulation of patients with cervical radiculopathy.

- There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living.
- There is limited evidence that electromagnetic therapy may be effective to reduce pain in mechanical neck disorders. If used, there should be a trial period with objective signs of functional progress.
- Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints,² or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain.
- Injecting botulinum toxin (type A and B) has been shown to be effective in reducing pain and improving range of motion (ROM) in cervical dystonia (a disorder that is non-traumatic and non-work-related). Mild side effects were fairly common and dose dependent, including dry mouth and dysphagia. While existing evidence shows injecting botulinum toxin to be safe, caution is needed due to the scarcity of high-quality studies. There are no high quality studies that support its use in whiplash-associated disorder.
- Cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise.
- Other miscellaneous therapies have been evaluated and found to be ineffective or minimally effective. For example, cervical collars have not been shown to have any lasting benefit, except for comfort in the first few days of the clinical course in severe cases; in fact, weakness may result from prolonged use and will contribute to debilitation. Immobilization using collars and prolonged periods of rest are generally less effective than having patients maintain their usual, "preinjury" activities.

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