

RYCO MedReview

DATE OF REVIEW: 07/24/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical epidural steroid injection under fluoroscopy with IV sedation

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

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with D.C. dated 10/04/04 and 01/14/05
An MRI of the lumbar spine interpreted M.D. dated 10/08/04
An MRI of the lumbar spine interpreted by M.D. dated 12/08/04
A DWC-69 form from M.D. dated 12/13/04
An EMG/NCV study of the lower extremities interpreted by M.D. dated 01/14/05
A letter of clarification from Dr. dated 05/26/05
An MRI of the cervical spine interpreted by M.D. dated 10/06/05

A Designated Doctor Evaluation with Dr. dated 11/07/05
A letter or clarification request from dated 11/14/05
A letter to Dr. from Disability Determination Examiner for TDI, dated 11/28/05
A Required Medical Evaluation (RME) with M.D. dated 12/29/05
A letter of approval from L.P.N., Utilization Review Nurse, dated 04/19/06
A Designated Doctor Evaluation with M.D. dated 05/02/06
Evaluations with D.C. dated 05/23/06, 09/25/06, 10/02/06, 10/04/06, 10/05/06,
and 12/27/06
A DWC-73 form from Dr. dated 06/15/06
An evaluation with M.D. dated 08/10/06
Evaluations with D.O. dated 09/15/06, 10/03/06, 11/06/06, 11/20/06, 12/11/06,
01/12/07, 02/01/07, 02/19/07, 03/23/07, 04/30/07, and 06/18/07
A questionnaire from the patient dated 09/18/06
A procedure report from Dr. dated 09/19/06
Chiropractic therapy with Dr. dated 09/27/06, 09/29/06, 10/02/06, 10/04/06, and
10/05/06
A Physical Performance Evaluation (PPE) with P.T. dated 01/02/07
A letter of non-authorization from L.V.N., Utilization Review Nurse, dated
01/24/07
A letter of adverse determination from R.N., Utilization Review Nurse, dated
05/11/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On 10/04/04, Dr. recommended further therapy three times a week for four weeks. An MRI of the lumbar spine interpreted by Dr. on 10/08/04 revealed mild disc bulging at L1-L2 and L3-L4, a disc protrusion at L2-L3, and a disc herniation with neural foraminal narrowing at L5-S1. An MRI of the lumbar spine interpreted by Dr. on 12/08/04 revealed mild disc bulging at L1-L2 and L2-L3 and a disc protrusion with severe disc space narrowing at L5-S1. On 12/13/04, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 10% whole person impairment rating. An EMG/NCV study interpreted by Dr. on 01/14/05 revealed bilateral L4 and an L5 or S1 radiculopathy. An MRI of the cervical spine interpreted by Dr. on 10/06/05 revealed a disc protrusion at C6-C7 and multilevel neural foraminal stenosis. On 11/07/05, Dr. placed the patient at MMI with a 25% whole person impairment rating. On 12/29/05, Dr. felt further treatment was not related to the original injury and he felt the patient should have been given a 15% impairment rating, not a 25%. On 05/02/06, Dr. placed the patient at MMI with a 0% whole person impairment rating. On 09/15/06, Dr. recommended a pain management program, Wellbutrin, Lyrica, and Darvocet. On 09/19/06, Dr. performed a lumbar epidural steroid injection (ESI). On 09/25/06, Dr. recommended rehabilitation. Chiropractic therapy was performed with Dr. on 09/27/06, 09/29/06, 10/02/06, 10/04/06, and 10/05/06. On 10/03/06, Dr. recommended a cervical ESI. On 11/06/06, Dr. noted the patient was pending a chronic pain program. On 12/27/06, Dr. recommended a home exercise program. On 01/12/07 and

06/18/07, Dr. recommended a cervical ESI blockade. On 01/24/07, Ms. wrote a letter of non-authorization for a cervical ESI. On 04/30/07, Dr. recommended lumbar ESI therapy. On 05/11/07, Ms. wrote a letter of non-authorization for the ESI.

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

This patient has allegedly been shown to have cervical radiculopathy. However, later notes including those by, D.O. indicate the patient is suffering at this time from mostly axial pain. ESIs have very poor utility in the treatment of axial pain. Recent guidelines published in both 2005 and 2007 in the journal Pain Physician indicate very limited utility for these procedures. In my opinion, therefore, the cervical ESI is neither reasonable nor necessary because it is not effective for this disease process. Reference includes the above mentioned guidelines, the *National Guidelines for the International Spinal Injection Society*, and ODG on ESIs.

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)

Pain Physician

National Guidelines for the International Spinal Injection Society