

# **RYCO MedReview**

**DATE OF REVIEW:** 05/16/07 (AMENDED 05/31/07)

**IRO CASE #:**

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

Cervical steroid epidural injection

## **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**

A CT scan of the cervical spine interpreted by Dr. (no credentials were listed) dated 07/23/03

Evaluations with M.D. dated 12/30/03, 01/09/04, 04/23/04, 06/24/04, 10/14/04, 11/29/04, 03/07/05, 05/31/05, and 08/29/05

An operative report from Dr. dated 11/11/04

Patient instructions from an unknown nurse (the signature was illegible) dated 11/29/04

An evaluation and EMG/NCV study with Dr. dated 01/18/05

A DWC-73 form from an unknown provider (the signature was illegible) dated 10/10/05

An evaluation with the unknown provider dated 10/10/05

Evaluations with M.D. dated 10/25/05, 11/15/05, 12/22/05, 01/23/06, 04/20/06, 05/17/06, 06/19/06, 07/17/06, 09/11/06, 11/15/06, 02/16/07, 03/15/07, and 04/12/07

Procedure notes from M.D. and M.D. dated 11/30/05, and 02/17/06

A letter of approval dated 01/20/06

An evaluation from an unknown provider (the signature was illegible) dated 02/17/06

Evaluations with an unknown provider (no name or signature was available) dated 03/23/06 and 04/03/07

An evaluation with Dr. dated 08/14/06

Evaluations with Dr. dated 10/09/06, 12/19/06, and 01/16/07

Letters of adverse determination dated 01/19/07, 02/14/07, 02/27/07, 03/21/07, and 04/12/07

A request for precertification from Dr. dated 03/21/07

A letter of request from Dr. dated 04/04/07

A request for precertification from Dr. dated 04/09/07

A letter of medical necessity from Dr. dated 04/23/07

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

A CT scan of the cervical spine interpreted by Dr. on 07/23/03 revealed a disc bulge at C7-T1 with foraminal stenosis and hypertrophy. On 12/30/03, Dr. performed a cervical epidural steroid injection (ESI). On 10/14/04, Dr. recommended an EMG and a cervical ESI. On 11/11/04, Dr. performed an ESI. An EMG/NCV study interpreted by Dr. on 01/18/05 revealed chronic radiculopathy of the left C7-C8 level. On 11/15/05, Dr. recommended injection therapy, Oxycontin, Trazodone, and Robaxin. On 11/30/05, Dr. performed a cervical ESI at C7-T1. On 02/17/06, Dr. performed a cervical ESI. On 01/16/07, Dr. requested injection therapy and continued medications. On 01/19/07, 02/14/07, and 02/27/07, wrote letters of adverse determination for the ESI and EMG/NCV study. On 02/16/07, Dr. requested an EMG/NCV study. On 03/21/07 and 04/12/07, further letters of adverse determination for the ESI.

On 04/23/07, Dr. wrote a letter of medical necessity for a repeat cervical ESI.

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

The patient has had two epidural injections over a prolonged timeframe, both of which gave her significant pain relief, according to the attending physician. The clinical notes do document good pain relief from those injections. A single cervical epidural steroid injection at this time is reasonable and necessary, based

on the criteria promulgated by the North American Spine Society, as well as the Spinal Injection Society.

**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)

North American Spine Society  
Spinal Injection Society