



## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WC (Non-Network)

**DATE OF REVIEW:** 02/15/10

**IRO CASE #:**

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

Cervical Epidural Steroid Injection with Fluoroscopy and Under Anesthesia

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

Board Certified in Physical Medicine & Rehabilitation

**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.

Cervical Epidural Steroid Injection with Fluoroscopy and Under Anesthesia - UPHELD

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Cervical Myelogram and Cervical CT Myelogram, M.D., 01/30/09
- Computerized Muscle Testing, Diagnostics, 05/22/09
- Electrodiagnostic Evaluation/EMG-NCV, D.C., 10/09/09
- Follow up Consultation, D.O., 12/16/09
- Pre-Authorization Request, M.D., 12/21/09
- Denial Letter, Mutual, 12/23/09, 01/06/10
- The ODG Guidelines were not provided by the carrier or the URA.

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient had cervical spine injuries that were sustained from a traumatic work-related incident. He had undergone a myelogram, as well as a CT myelogram. An electro-diagnostic

evaluation/EMG and NCV was also performed. He had been treated with Gabapentin, Medrol Dose Pack, Hydrocodone, Tylenol and Neurontin.

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

Based upon the medical documentation currently available for review, there would not appear to be a medical necessity for treatment in the form of a cervical epidural steroid injection. There is a documented diagnosis of a cervical post laminectomy syndrome. The records available for review would appear to indicate that cervical spine surgery was performed due to the lack of a positive response to conservative attempts at medical treatment, which included an attempt at treatment in the form of therapeutic injections to the cervical spine. Thus, per criteria set forth by Official Disability Guidelines, medical necessity for a cervical epidural steroid injection at the present time would not be established, as the records available for review do not provide any documentation that there was a definitive significant positive response to previous attempts at a therapeutic injection to the cervical region. Consequently, based upon the records available for review, Official Disability Guidelines would not presently support a medical necessity for treatment in the form of a cervical epidural steroid injection. The Official Disability Guidelines state that there must be documentation to indicate that previous attempts at a cervical epidural steroid injection were of significant benefit to support a medical necessity for ongoing treatment of this nature. The records available for review do not provide any documentation indicating that there was a significantly positive response to past attempts at therapeutic injections.

**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)