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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 4/13/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient Cervical Epidural Steroid Injection (ESI) w/Fluoroscopy (ICD-9/DSMV 722.0)

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

Physician Board Certified in Neurological Surgery

DESCRIPTION OF THE REVIEW OUTCOME THAT CLEARLY STATES WHETHER OR NOT MEDICAL NECESSITY EXISTS FOR EACH OF THE HEALTHCARE SERVICES IN DISPUTE.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> Partially Overturned	(Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 4/04/12, 3/16/12, 3/08/12

Peer Medical Record Review, 10/03/11

Clinical Notes, 3/01/12 – 9/13/99

Clinical Notes, 2/18/11, 11/30/10

Cervical Spine Series/MRI, 3/01/12 - 10/18/10

Operative Rpt/Discharge Summary, 7/20/11, 7/19/11

ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a now male who, in xx/xxxx, was lifting over his head and struck his head. He developed pain in his neck and right shoulder. He had physical therapy and medications with no results. An MRI on 1/14/98 showed straightening of the lordotic curve, but no disc herniation or any other sources of nerve root pressure. A 5/19/98 electrodiagnostic test showed "C7-8, T1 radiculopathy". A cervical CT myelogram on 6/08/98 showed minimal annular bulging at C6-7 and a broad-based disc bulge at C5-6 mainly on the left side. Examination on 9/3/98 is reported as showing no reflex sensory or motor deficit. Epidural steroid injections in September and October of 1998 were not helpful. A cervical discography on 8/23/99 was positive at the C5-6 level and this apparently led to an anterior cervical discectomy and fusion at that level. The exact date and details of that operation, and subsequent operations on the cervical spine, are not available until the operation performed by on 7/19/11. That operation consisted of

exploration of the C5 -6 level with removal of the plates anteriorly and an anterior cervical discectomy and fusion at the C6-7 level with plating being placed. Post-operatively, the patient was doing well at three months. At seven months, however, despite a cervical spine film showing nothing in the way of significant abnormalities, the patient was developing right shoulder and neck pain. The cervical spine films are of significance, to note, that it was reported by the radiologist that there was a break in one of the vertebral screws at the C6-7 level. Those x-rays were done on 3/01/12.

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

I agree with the denial for the cervical epidural steroid injections. The number of surgeries this patient has had on his cervical spine indicates significant scarring probably being present. Epidural steroid injections under these circumstances are often much less effective and give even less time of transient relief than is present in a less scarred, cervical region. There are complications of epidural steroid injections in the cervical spine and with the patient already exhibiting myelopathy, I think these complication possibilities are increased. recommends a CT scan of the cervical spine if the epidural steroids are refused. This is thought appropriate and may show some additional reasons not to do epidural steroid injections, but instead, something more definitive in the way of a surgical procedure.

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)**