



## Medwork Independent Review

1217 Menomonie Street  
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1-800-426-1551 | 715-552-0746  
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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Network (WCN)*

01/07/2008

**DATE OF REVIEW: 01/07/2008**

**IRO CASE #:**

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

Cervical Epidural Steroid Injection

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management physician

**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**

1. Texas Dept of Insurance Assignment to 12/18/2007
2. Notice to URA of assignment of IRO dated 12/18/2007
3. Confirmation of Receipt of a Request for a Review by an IRO 12/17/2007
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO, patient request 12/14/2007
6. Letter (Post Appeal Review) 11/28/2007
7. xxxxxx letter (Appeal Prospective) 11/27/2007
8. Letter (Peer Review Triggered) 11/16/2007
9. xxxxxx letter (Appeal Prospective) 11/16/2007
10. Office note: 11/28/2007; 11/05/2007; 09/20/2007; 07/26/2007/; 07/12/2007; 06/21/2007; 06/05/2007; 05/23/2007; 03/07/2007 (Visual & Brain Stem Evoked Potential); 03/05/2007 (EMG/NCV); 02/11/2007 MRI cervical spine w/o contrast



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11. ODG guidelines were not provided by the URA

### **PATIENT CLINICAL HISTORY:**

This is a xx-year-old female who sustained a work-related injury on xx/xx/xx involving the neck injured while loading trucks for .

Following conservative treatment, the claimant underwent a cervical MRI performed on February 10, 2007 which revealed at the C3-4 level a posterior left subarticular disk protrusion indenting the ventral lateral aspect of the thecal sac and possible mass effect upon the ventral rootlet of C-4 on the left; at the C5-6 level, there is a broad-based posterior central disk protrusion mildly indenting the ventral aspect of the thecal sac without spinal stenosis or neural foraminal narrowing. Subsequent to this, an electrodiagnostic testing of the upper extremities performed on 03/05/07 by Dr., M.D. revealed evidence of left C-4 radiculopathy. Patient continued to complain of increasing pain to the neck and left arm. Clinical diagnosis: cervical disk displacement without myelopathy; cervical sprain/strain; & cervical radiculopathy.

From the information submitted, claimant underwent two cervical epidural steroid injections, the first performed on 06/11/07 with a follow-up evaluation on 06/21/07. In this note, claimant reported the injection helped the pain and decreased it, but it has come back significantly. Of note, only ten days have passed since the first injection. The second injection (CESI) was performed on 07/12/07 with a post-injection follow-up performed 07/26/07. In this note reportedly, claimant is a lot better, performing physical therapy, taking two to three Darvocet per day with continued complaints of neck pain. The patient continues to work. Of note, the submitted documentation does not report percentage of pain relief, improvement in function and/or decrease of medication intake following the interventional pain management injection.

In the last submitted follow-up note for review dated 11/28/07, requesting provider reports that claimant is basically capable of being extremely functional in getting back to work; for this reason, he now will request authorization for patient to be admitted to his chronic pain/rehabilitation program (multidisciplinary pain program); this is aimed to help patient come off medications and get back to work. Clinical examination pertaining to the cervical spine reveals guarded range of motion and flexion to about 25 degrees, significant degree of paraspinal muscle spasm, range of motion testing of the shoulder is normal, no tenderness over the bicipital groove, Hawkins' test is negative, neurological examination of the upper extremities is within normal limits, Spurling's test is negative, and examination of the anterior cervical triangle is unremarkable. Current clinical impression: Cervical myofascial pain probably secondary to cervical radiculopathy.

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

After reviewing the information provided, the previous nonauthorization for cervical epidural steroid injection has been upheld because: 1. Lack of documented efficacy with the first two cervical epidural steroid injections i.e. percentage of pain relief, decrease in medication intake, and improvement functionally; 2. Lack of available related clinical information in support of the application, particularly no information regarding the presence of significant objective radiculopathy exists on the follow-up notes submitted.



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Guideline references used: Official Disability Guidelines, Treatment Index, Fifth Edition 2006/2007 under Cervical ESI & ACOM Guidelines, Second Edition, Chapter 8 and Chapter 12.

### **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)