



Medwork Independent Review

1217 Menomonie Street
Eau Claire, Wisconsin 54703
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
medworkiro@charterinternet.com
www.medwork.org



NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

01/07/2008

DATE OF REVIEW: 01/07/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical epidural block (cervical epidural steroid injection) with epidurogram under fluoroscopy

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 12/19/2007
2. Confirmation of Receipt of a Request for a Review by an IRO 12/18/2007
3. Company Request for IRO Sections 1-8 undated
4. Request For a Review by an IRO, patient request 12/17/2007
5. Letter (Post Appeal Review) 11/28/2007
6. Adverse Determination/Appeal Preauth UR 12/13/2007
7. Adverse Determination/Initial Pre auth UR 11/19/2007
8. IRO Summary 12/20/2007
9. DWC First Report of Injury xx/xx/xx; OSHA Form 301; Associate Statement 05/31/2007; WC Request for Medical Care 05/31/2007



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10. TWC Work Status Reports 12/18/2007; 11/06/2007; 10/22/2007; 09/21/2007; 09/07/2007; 08/24/2007; 08/09/2007; 08/03/2007; 07/27/2007; 07/20/2007; 07/06/2007; 06/19/2007; 05/31/2007
11. Office notes 11/27/2007; 10/30/2007; 10/22/2007; 09/21/2007; 09/07/2007; 08/30/2007; 08/24/2007; 08/09/2007; 08/03/2007; 07/27/2007; 07/20/2007; 07/06/2007; 06/19/2007; 05/31/2007
12. Electrodiagnostic Study 09/19/2007
13. MR cervical spine 08/01/2007
14. Xray RT & LT shoulder 05/31/2007
15. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This is a xx-year-old male, who sustained a work-related injury on xx/xx/xx involving the neck/shoulder subsequent to a lifting type mechanism. The claimant evaluated by a Dr. , M.D. on 05/31/2007 with a chief complaint of left shoulder/right shoulder pain. Clinical examination was specific for shoulder examination. The patient treated conservatively through August 2007 of which he was then referred to a., M.D. (physical medicine rehab physician), who diagnosed patient with cervicalgia and acromioclavicular joint sprain. A subsequent MRI was performed on 08/01/2007 revealing 2 mm disk bulges at C3-4 and C4-5 levels, at the C5-6 level, a 2 to 3 mm disk protrusion with mild central canal stenosis and moderate bilateral neural foraminal narrowing and at the C6-7 level, a broad 1 mm disk bulge. Subsequent to this, an EMG/nerve conduction study performed on 09/19/2007 revealed electrodiagnostic evidence consistent with right C6 radiculopathy. On October 30, 2007, the claimant evaluated by requesting physician, Dr., D.O., whose physical examination revealed decreased range of motion of the cervical spine on rotation/extension; no weakness in the upper extremities; deep tendon reflexes 2+/4, biceps, triceps, brachioradialis, and patient has positive neck pain/right shoulder pain. A request at that time was made for cervical epidural steroid injection. Of note, the initial examination submitted did not provide any information regarding the presence or absence of sensory motor deficits in the upper extremities or any other associated findings indicative of cervical radiculopathy. It appears that the request for a cervical epidural steroid injection was denied on two separate occasions by two different reviewing physicians. On November 27, 2007, a reevaluation by Dr. now describes in his clinical examination decreased sensation in the C5-6 distribution on the right.

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

After review of the information submitted, the previous non-authorization for cervical epidural steroid injection with the use of fluoroscopy under anesthesia is upheld because of lack of available relevant clinical information support the application, particularly no information regarding the presence of significant consistent objective radiculopathy exists on the follow up notes submitted. The patient seems to have no symptoms indicative of a C6 radiculopathy pattern. The requesting provider's physical examinations do not correlate.



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Official Disability Guidelines specifically state the criteria used for epidural steroid injection must include radiculopathy documented by physical examination and cooperated by imaging studies and/or electrodiagnostic testing, which is simply not the case here.

Guidelines/References Used: Official Disability Guidelines, Treatment Index, 5th edition 2006/2007 & ACOM Guidelines, 2nd Edition, Chapters 8 and 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 KNOWLEDGBASE**
- 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)**



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- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**