



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

DATE OF REVIEW: 11/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical Translaminar 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 Orthopaedic Surgeon

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 11/06/2009
2. Notice of assignment to URA 11/06/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 11/05/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 11/04/2009
6. letter 10/28/2009, 10/08/2009, letter to IRO 11/11/2009
7. Pre-cert rqst 10/20/2009 & 10/06/2009, referral form 09/30/2009, medical notes 09/30/2009, 08/31/2009, 08/24/2009, 07/22/2009, 06/24/2009, 05/27/2009, 05/18/2009, 05/04/2009, radiology reports 09/14/2009, MRI 04/17/2009
8. ODG neck & upper back (acute & chronic) & ESI

PATIENT CLINICAL HISTORY:

The claimant has a work related injury xx/xx/xx. The patient developed pain into his neck and right shoulder. Patient complains of difficulty turning his neck from side to side. The imaging studies on this patient have not shown any neural compression in the cervical spine. The examination has not shown any evidence of radiculopathy. Specifically, reflexes are intact, sensation is normal, and motor strength is normal. There is a negative Spurling sign. There is a negative Lhermitte sign. There has been a request made for this patient to undergo a cervical epidural steroid injection.

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



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There are no imaging findings of neural compression, and in view of the fact that the physical exam does not reveal any evidence of radiculopathy, it is not medically necessary, and not in keeping with Official Disability Guidelines, for this patient to have a cervical translaminal epidural steroid injection. The previous adverse determination is upheld.

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)