

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

**DATE OF REVIEW: 10/07/2009**

**IRO CASE #:**

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

Left C6 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 Physical Medicine & Rehab 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. Assignment to 09/18/2009
2. Notice of assignment to URA 09/18/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 09/17/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 09/17/2009
6. determination letter 08/31/2009, 08/12/2009
7. Fax pre-cert 08/06/2009, consult 08/04/2009, follow up 06/29/2009
8. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

This male sustained, on xx/xx/xx, an occupational injury resulting in a C5-C6 trauma, which required anterior cervical discectomy/fusion procedure in October 2008. The claimant has remained symptomatic with occasional numbness of the left arm. However, there is persistent neck and shoulder pain. The pain is worse with extension of the cervical spine and rotation to the left. It is relieved with the muscle relaxant medication, Soma, and the recumbent position. This pain is increased with coughing, sneezing, sitting, and standing. The claimant underwent a postoperative cervical MRI scan demonstrating a C5-C6 disk protrusion with mild central canal stenosis and mild foraminal stenosis.

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

The requested left C6 epidural steroid injection is not medically indicated because the claimant does not demonstrate evidence of a left C5-C6 radiculopathy. The upper extremity examination is demonstrating no focal motor/sensory impairment and the repeat postoperative cervical spine MRI scan is demonstrating a new small disk protrusion at C5-C6 without clear evidence of neurocompression. This request therefore is not within the Official Disability Guidelines with regard to epidural steroid 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)