



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

DATE OF REVIEW: 8/11/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical ESI at C4-C6 on the right with fluoro.

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

Texas State Licensed MD Board Orthopedic 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.

PATIENT CLINICAL HISTORY:

The claimant was reportedly been in a motor vehicle accident in xx/xxxx. Despite treatment, he was noted to have neck pain with a radiation into the arms along with numbness and tingling also.

It had most recently been documented to reveal cervical spine tenderness and along with an intact neurologic examination. The record as of 05/22/2014 documented the indication for Celebrex and with ESI and that the assessment was "neck pain with radiculopathy... had rollover incident... had degenerative spondylosis with disk herniation of multiple levels in the cervical spine. He also has radiculopathy associated with this." Again, the exam findings revealed 2+ and symmetric reflexes with intact sensation and motor power along with poor range of motion at the cervical spine motion that was noted to be painful. The history had included treatment with medications, altered activities, and therapy.

Discussed the lack of objective clinical evidence of radiculopathy and the lack of detailed evidence of non-operative/conservative treatment. The MRI had been noted as of 03/27/2014 to reveal a focal herniation/bulge at C4-C5 with foraminal narrowing and a bulging and right-sided central disk herniation at C5-C6 with canal stenosis and asymmetric foraminal narrowing.



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

The claimant's clinical findings do not evidence objectively abnormal neurologic findings with regards to sensation and/or motor power and/or reflexes as corroborated by the MRI. The detailed documentation of the prior treatments including therapy and medications have also not been provided. Therefore, the request is not reasonable or medically necessary, based on the applicable ODG criteria for cervical epidural steroid injections as referenced below.

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)