



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

DATE OF REVIEW: 2/10/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Thoracic 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 Anesthesiologist and Pain Medicine 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

PATIENT CLINICAL HISTORY:

The patient is a male who reported an injury on xx/xx/xx. The patient incurred multiple rib fractures and blunt trauma to the neck and upper back region. Documentation submitted did not indicate any surgery was performed following this injury. On the last note submitted by the treating physician dated 10/21/2013, the patient continues with persistent back and neck pain at a severity level of 6. The patient describes the pain as aching, deep, sharp, shooting, throbbing, and gnawing. Symptoms are aggravated with daily activities. The patient is relieved with medication and rest. The patient describes a radiating pain at T5-6 level approximately 2 inches bilateral from the midline. Clinical examination of thoracic spine reveals tenderness noted throughout the paraspinous and spinous processes area. Motor and neurologic tests, lower extremities normal.

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

Chronic pain syndrome, degeneration thoracic spine, displacement thoracic intervertebral disk, backache, degeneration cervical disk, sacroiliitis, numbness and tingling, cervical spinal stenosis. Submitted thoracic magnetic resonance imaging (MRI) without contrast dated 10/30/2013



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reveals mild thoracic degenerative disk changes; posterior disk protrusion causing mild canal stenosis T4-5 and T9-10 level; facet osteoarthritis present at T3-4 level and within the lower thoracic segments, and mild chronic compression fracture at T3 level. After review of the information submitted, the previous denial for the request of thoracic epidural steroid injections has been upheld. Official Disability Guidelines on the Pain Chapter state that epidural steroid injections are recommended as a possible option for short-term treatment of radicular pain with the use and conjunction with active rehabilitation efforts. Radiculopathy must be documented by objective findings on examination and corroborated by imaging studies and/or electrodiagnostic testing. The follow-up note submitted did not provide any information regarding the absence of sensory, motor, or reflex deficits or any other associated findings indicative of thoracic radiculopathy. Additionally, the thoracic magnetic resonance imaging (MRI) did not reveal any significant thoracic disk herniation, nerve root compression, and/or spinal stenosis. Additionally, documentation did not indicate any failure of conservative treatment which include physical therapy and/or medication management. It appears the requesting provider requests the thoracic epidural steroid injection in that the lack of performance of this procedure will result in erroneous finding of maximal medical improvement and/or delay in determination of maximal medical improvement percentage. In accordance with ODG guidelines as stated above, the medical necessity of the request could not be established and is not certified and the previous nonauthorization has been 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



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- 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)**