



## Medwork Independent Review

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### *MEDWORK INDEPENDENT REVIEW WC DECISION*

**DATE OF REVIEW:** 03/21/2016

**IRO CASE #:**

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

Right cervical ESI @C6-7

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

Texas State Licensed MD Board Chiropractic.

### **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 is a female who claims injury in a work incident dated XX/XX/XX. The claimed injury region is the neck and lower back. She also claims injury to her knee. Prior intervention includes left knee meniscectomy and postoperative therapy.

Cervical MRI report dated XX/XX/XX revealed a 3 mm broad-based posterior disc protrusion lateralized into the left at C6 – C7. There was no mention of nerve root compression.

The record includes a request for authorization dated XX/XX/XX. The request is for right C6 – C7 cervical epidural steroid injection. The request states that the patient complains of continued neck, low back, and knee pain. The patient has undergone 12 sessions of postoperative rehabilitation to the knee.

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

The patient is maintained on medication therapy. The request notes 3 mm broad-based protrusion lateralized into the left at C6 – C7. A smaller 2 mm broad-based protrusion was noted at C3 – C4. Provocation maneuvers were noted in the cervical spine. Range of motion was described as restricted. Palpation noted tenderness and spasm in the lumbar spine. Therefore the denial of these services are upheld.



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### 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)