



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

Workers' Compensation Health Care Non-network (WC)

12/31/2007

DATE OF REVIEW: 12/31/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Epidural Steroid Injection #3

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management 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. Texas Dept of Insurance Assignment to 12/11/2007
2. Notice to URA of assignment of IRO dated
3. Confirmation of Receipt of a Request for a Review by an IRO 12/10/2007
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO, patient request 12/10/2007
6. Letter dated 12/14/2007
7. ODG TWC Treatment- Intregrated Treatment/Disability Duration Guidelines
8. HDI Reconsideration/Appeal of Adverse determination dated 11/28/2007
9. HDI UR Determination dated 11/13/2007
10. Request for a lumbar epidural steroid injection (#3) to be presented for medial dispute 11/30/2007
11. Epidural steroid injection follow up questionnaire 10/31/2007
12. Lumbar Epidural Steroid Injection #2 10/31/2007 & #1 10/11/2007
13. Neurological Surgery Consultation (H&P) 11/19/2007
14. MRI Spine w/o contrast 09/11/2007



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PATIENT CLINICAL HISTORY:

This is a xx-year-old male who sustained a work-related injury on xx/xx/xx involving the lumbar spine secondary to a lifting type mechanism. Current diagnoses are: 1) Lumbar discogenic pain; 2) Subjective numbness and tingling of the lower extremities. Subsequent to the injury, claimant underwent conservative treatment consisting of physical therapy and medication management. The patient initially rated back pain score of 8/10. Medication management to include hydrocodone. Clinical examination pertaining to the lumbar spine reveals no paravertebral spasm or tenderness along the paravertebral musculature, heel and toe walk able to be performed, claimant is able to bend over and grab his knees, straight leg raising at 90 degrees only causes low back pain, lumbar extension causes pain to the lower back; motor strength of the lower extremities 5/5, sensation intact to lower extremities with deep tendon reflexes symmetrical.

Reportedly, a lumbar MRI submitted dated 09/11/07 reveals at the L3-4 level, a 2 mm bulge flattening the ventral thecal sac with annular fissures, at the L4-5 level a 5 mm left paracentral protrusion indents the thecal sac causing mild central stenosis; the protrusion narrows the left subarticular recess containing the left L-5 nerve root. There is no foraminal stenosis; at the L5-S1 level, a 2 mm bulge extends into the anterior epidural fat without effacing the thecal sac or nerve roots.

It appears from the requesting provider that he is requesting a third lumbar epidural steroid injection. This, of course, means that claimant has undergone at least two lumbar epidural steroid injections (date not specified). In addition, there are no notes from the requesting provider stating the efficacy documented from these injections. Furthermore, denials from the Utilization Review determinations state that there is no objective radicular component occurring on the work-ups previously performed for this patient.

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

I have reviewed the information submitted. The request for a third lumbar epidural steroid injection has been denied. ODG Guidelines clearly state ESIs are recommended after meeting certain criteria "radiculopathy must be documented". Objective findings on examination must be seen. Furthermore in the therapeutic phase, which I believe this patient is in, repeat block should only be offered if there is at least 50-70 percent pain relief for at least six to eight weeks with general recommendations of no more than four blocks per region per year.

Repeated injections should be based on continued objective documented pain and functional response. From the information submitted, this has not been documented. Current research does not support a routine use of a "series of three injections in either the diagnostic or therapeutic phase".

The review outcome is upheld. I agree with the prior non authorization determination. From the guidelines above as stated, there is no medical necessity at this time to proceed with the three lumbar epidural steroid injections.



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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 KNOWLEDGBASE
- 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)