



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

Workers' Compensation Health Care Non-network (WC)

Original Decision Date: 12/11/2007

Amendment Date: 12/18/2007

DATE OF REVIEW: 12/11/2007

IRO CASE

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Rt L3-4, L4-5 Transf ESI w/ Fluro

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

Texas State Licensed MD Board Certified Orthopaedic 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment to 11/30/2007
2. Notice to URA of assignment of IRO dated 11/30/2007
3. Confirmation of Receipt of a Request for a Review by an IRO 11/29/2007
4. Company Request for IRO Sections 1-8 undated
5. Patient request for a Review By an IRO 09/24/2007
6. DWC Preauthorization Report & Notification dated 08/10/2007
7. DWC Preauthorization Report & Notification (appeal) dated 09/07/2007
8. Orthopaedic Surgery Group Fax cover undated
9. Corp Preauthorization Request Form Fax undated
10. MRI lumber spine dated 07/06/2007



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11. Office notes dated: 09/05/2007, 08/20/2007, 08/07/2007, 07/23/2007, 06/04/2007, 05/08/2007, 02/03/2006 (medical record review), 12/16/2005, 12/05/2005, 11/11/2005, 11/08/2005, 10/24/2005, 09/23/2005, 08/23/2005, 08/01/2005, 07/19/2005, 07/08/2005, 06/23/2005, 05/17/2005, 05/03/2005, 04/21/2005, 04/19/2005, 04/08/2005, 04/07/2005, 03/29/2005, 03/22/2005, 03/20/2005, 03/18/2005, 03/11/2005, 03/04/2005, 02/25/2005, 02/17/2005, 10/05/2004, 09/07/2004, 08/12/2004, 08/10/2004 (peer review), 08/10/2004 (peer review)
12. ODG Guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This is an individual, who has presented with low back and right leg pain. The patient was originally seen by Dr.. Subsequently, the patient had been seen by Dr.. Dr. has recommended an epidural injection. I have reviewed the records. According to the records, this patient previously received epidural steroid injections and got marked and significant pain relief. At this time, an MRI report has been reviewed. It is dated July 6, 2007. There is an annular tear and disk bulging with foraminal stenosis as well as central stenosis.

I have reviewed the records of August 7 and September 5, 2007. In both those records, there was documentation that the patient does have radicular complaints and findings.

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

In accordance with the North American Spine Society review on the use of epidural steroid injections, I agree that epidural steroid injections can be useful in the treatment of patients particularly who have radicular complaints and findings. That would appear to be the case with this individual.

Epidural steroid injections have also been found to be useful in patients with radicular complaints in the InterQual Criteria and is generally accepted as a medical standard.

In my opinion, the decision should be overturned. I support the use of epidural steroid injections in this patient.

ODG guidelines support the use of epidural steroids if there are radicular symptoms and findings. This patient has benefited from epidural steroids in the past. There are also positive nerve root tension signs.

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



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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)