



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

02/20/2008

DATE OF REVIEW: 02/20/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar 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 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 01/31/2008
2. Notice to URA of assignment of IRO
3. Confirmation of Receipt of a Request for a Review by an IRO 01/30/2008
4. Company Request for IRO Sections 1-8
5. Request For a Review by an IRO patient request 01/29/2008
6. Letter Appeal Pre-auth 01/15/2008
7. Letter Initial Pre-auth 12/31/2007
8. Fax cover for pre-auth request 01/15/2008
9. DNI letter for pre-auth 01/11/2008
10. SOAP note 01/07/2008
11. Fax cover for pre-auth request 12/31/2007



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12. Procedure note 12/20/2007
13. Request for ESI lumbar pain management 12/11/2007
14. Office note 12/06/2007
15. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This is a male who sustained a work-related injury involving the lumbar spine secondary to a rollover MVA. Claimant was initially complaining of low back pain with pain radiating down the left lower extremity. Conservative treatment included physical therapy and medication management. Reportedly, a lumbar MRI performed was consistent with disk desiccation at L4-5 level with some loss of the normal disk height with some disk bulging/mild facet arthropathy. Clinical examination specific to the lumbar spine revealed normal gait, significantly restricted motion in all planes of the lumbar spine to flexion, extension, and side bending; significant amount of paravertebral muscle spasm, heel and toe walk performed, positive straight leg raise on the left; reflexes symmetrical/with good strength; negative Faber and Patrick's sign. Medication management consisted of Lortab, Soma, and Celebrex. Claimant underwent a left-sided interlaminar lumbar epidural steroid injection on 12/20/07 with reported 10-30 percent relief of symptoms. An epidural steroid injection follow-up questionnaire submitted with this review states that the patient's pain level went from a 7 on a 0-10 scale down to 6. Patient reported on this questionnaire somewhat decrease in pain.

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

After reviewing the information submitted, the request for a second lumbar epidural steroid injection has been denied. Official Disability Guidelines state that a second block (LESI) is not recommended if there is inadequate response to the first block. To be considered successful after the first block, there should be documentation of at least 50-70 percent relief of pain from baseline and evidence of improved function for at least six to eight weeks after delivery. Therefore due to the lack of efficacy with the previous lumbar epidural steroid injection (significant decrease in pain, improvement in function, and decrease in medication intake), additional lumbar epidural steroid injections is not warranted. Guidelines and References used: Official Disability Guidelines, Treatment Index, Fifth Edition 2006/2007 under "Low Back - Epidural injections", & ACOEM Guidelines, Second Edition, chapters 6, 8, and 12.

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



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- 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)**