



## Medwork Independent Review

1217 Menomonie Street  
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1-800-426-1551 | 715-552-0746  
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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)*

**DATE OF REVIEW: 05/05/2008**

**IRO CASE #:**

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

Lumbar transforaminal ESI bil L3-L4

**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 Medwork 04/162008
2. Confirmation of Receipt of a Request for a Review by an IRO 04/16/2008
3. Company Request for IRO Sections 1-8 undated
4. Request For a Review by an IRO patient request 04/14
5. letter 1<sup>st</sup> appeal 04/04/2008
6. letter UR 03/07/2008
7. Patient listing of providers
8. Letter from Dr. 02/21/2008
9. Imaging & Diagnostic 01/25/2008
10. Care Consultants 01/17/2008
11. Medical Center 11/14/2007
12. Hospital 11/21/1994, 11/15/1994
13. ODG guidelines were provided by the URA

**PATIENT CLINICAL HISTORY:**

This is a male who sustained a work-related injury involving the lumbar spine secondary to a lifting type mechanism. Subsequent to the injury, on 11/21/94, the claimant underwent bilateral decompressions at L3-4 and L4-5 levels with fusion. In January of 2008, the claimant was referred to pain management physician M.D. with a chief complaint of bilateral midlumbar pain



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with a pain score of 7-8/10. Current medication management consisted of Neurontin 300 mg three times a day, Lortab t.i.d., and Baclofen 10 mg t.i.d. p.r.n. Clinical examination revealed straight leg raising positive on the right; motor examination of lower extremities normal; reflexes lower extremities bilateral patellar and ankle jerk 0+/5. CT scan of the lumbar spine without contrast submitted on 01/25/08 revealed posterior fusion L4-5 through L5-S1 levels with neural foramina patent at the L3-4, L4-5, and L5-S1 levels. From the previously performed Utilization Review Determination, reportedly requesting provider (Dr.) has previously performed bilateral transforaminal epidural steroid injections at levels L2-3 and L3-4. Reportedly, there was no documentation on the efficacy of the procedures, specifically decrease in pain score, increase in function, and decreased medication intake.

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

The previously noncertification for bilateral lumbar transforaminal epidural steroid injections at L3-4 level is upheld. Requested intervention does not meet the criteria according to the Official Disability Guidelines to include: Unequivocal evidence of radiculopathy must be present (defined as pain in dermatomal distribution with cooperative findings of radiculopathy, i.e. lumbar MRI and/or CT scan). There is no documentation submitted from the previous injections of at least 50-70% pain relief from baseline and evidence of improved function for at least six to eight weeks following the injections.

Guidelines and References used:

1. Official Disability Guidelines, Treatment Index, Fifth Edition 2006/2007 under Low back/epidural injection.
2. American Society Pain Management Positions Practice Guidelines.

### **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



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- 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)