



Medwork Independent Review

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

DATE OF REVIEW: 04/22/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level

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 04/02/2009
2. Notice to URA of assignment to IRO 04/02/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 04/02/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 04/01/2009
6. Daily progress note 04/03/2009
7. appeal of a non certification determination letter 03/26/2009
8. Professional Reviews 03/25/2009
9. utilization review letter 03/19/2009
10. Professional Reviews letter 03/19/2009
11. Pre authorization first request 03/16/2009
12. Medical note 03/16/2009 & Log note 03/16/2009
13. Functional Abilities Evaluation 03/13/2009
14. Progress note 02/24/2009
15. Medical note 02/20/2009
16. Functional Capacity Evaluation 02/02/2009
17. Medical note 01/21/2009, 01/16/2009, 12/02/2008
18. Medical Record review 11/10/2008
19. CT lumbar spine 10/22/2008
20. MRI lumbar spine 10/21/2008
21. Workers' Compensation Initial Evaluation Report 10/20/2008
22. ODG guidelines were not provided by the URA



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PATIENT CLINICAL HISTORY:

On xx-xx-xx, patient was lifting a heavy box and injured his low back. Since that time the patient has had low back pain radiating to the buttocks, the hips, the legs, and the feet bilaterally. Pain is 5 on a scale of 0-10. The pain is constant, severe, and stabbing in nature. On physical exam there is decreased range of motion with tenderness in the low back. There is weakness in the left leg and foot. There are sensory deficits in the S1 distributions bilaterally. Straight leg raises are positive bilaterally. Positive FABER test on the left. Patient has had treatment with physical therapy, TENS unit, and previous epidural steroid injection. Patient is on Percocet. MRI shows laminar function at L5 with narrowing at the L5-S1 space, and there was an EMG that showed no lumbar radiculopathy. There is no documented percentage pain relief.

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

The Official Disability Guidelines' chapter on low back pain under epidural steroid injection, repeat injection should only be offered if the patient received 50%-70% pain relief from the previous one. There is no documentation of what type of percentage pain relief the patient got from the previous epidural steroid injection, therefore this is denied due to lack sufficient records to support the medical necessity.

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)