



Medwork Independent Review

5840 Arndt Rd., Ste #2
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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

08/19/2009

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 08/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural steroid injection @ L5-S1

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/Spine 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 Medwork 07/30/2009
2. Notice of assignment to URA 07/30/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 07/29/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 07/24/2009
6. determination letter 07/28/2009, 07/17/2009
7. Fax cover auth 2nd request not dated, medical note 07/08/2009, OT order 07/17/2009, order form 07/07/2009, fax cover auth request not dated, order form 05/20/2009, medical note 05/20/2009, MRI 04/09/2009, daily notes: 04/08/2009, 04/07/2009, 04/02/2009, 03/31/2009, 03/30/2009, 03/26/2009, 03/25/2009, 03/23/2009, 03/19/2009, 03/16/2009, 03/13/2009, 03/12/2009, 03/11/2009, 03/05/2009, 03/04/2009, 03/03/2009, 02/26/2009, 02/25/2009, 02/23/2009, 02/19/2009, 02/17/2009, 02/16/2009, 02/13/2009, 02/11/2009, 02/05/2009, 02/03/2009, 02/02/2009, 01/30/2009, 01/29/2009, hospital records 01/26/2009, radiology reports 01/26/2009
8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:



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This patient sustained an injury xx/xx/xx. MRI scan has shown a central disc herniation at the L5-S1 level. The patient has had some radicular complaints. She was sent for an epidural steroid injection. A submission has been made for an additional epidural steroid injection.

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

There is not actual report of the epidural steroid injection within the review records presented. There also isn't documentation of quantification of how much improvement there was following the epidural steroid injection, and there is no quantification for the duration of that relief. In the absence of the above-mentioned information, an additional epidural steroid injection should be denied. Using the Official Disability Guidelines, an additional epidural steroid injection would be useful if the initial injection gave 50% to 70% relief and if it was with some sustained time period.

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
- AHCP- 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)