



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

DATE OF REVIEW: 12/08/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L5-S1 ESI injection (62311, 62284, 77003, 72275)

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 11/20/2009
2. Notice of assignment to URA 11/20/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 11/19/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 11/18/2009
6. letter 11/09/2009, 10/16/2009
7. Pre-auth 11/02/2009 & 10/30/2009, medical note 10/30/2009, electro diagnostic interp 10/23/2009, MRI 10/08/2009, medical note 10/08/2009, 09/14/2009, TDI for, 11/10/2009
8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

Patient is status post injury to the low back, and patient has pain in the low back that radiates into the buttocks and into the legs. Patient's pain is 10 on a scale of 0-10, and on physical exam there is tenderness with decreased range of motion in the low back with a positive straight leg on the right. On EMG, there is positive L5-S1 radiculopathy. An MRI shows disc protrusions at L2-L3, L3-L4, and L4-L5. Request is for L5-S1 ESI injection (62311, 62284, 77003, & 72275).

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



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Referring to the Official Disability Guidelines' chapter on low back pain under epidural steroid injections, states that radiculopathy must be documented for epidural steroid injection and patient has to have failed conservative therapy. It is felt that the patient meets the ODG criteria; therefore the request is approved.

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
- 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)