



Medwork Independent Review

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

02/19/2009

DATE OF REVIEW: 02/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient diagnostic Left L-5 selective nerve root 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 to 1/30/2009
2. Texas Dept of Insurance notice of assignment of IRO
3. Confirmation of Receipt of a Request for a Review by an IRO
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 01/28/2009
6. appeal of adverse determination 01/20/2009
7. UR review determination 12/22/2008
8. letter 12/16/2008
9. review letter 11/26/2008
10. UR review 11/12/2008
11. reconsideration appeal of adverse determination 11/08/2008
12. UR review 11/05/2008
13. UR review 10/29/2008
14. UR review 10/01/2008
15. letter 09/09/2008
16. Texas report of medical evaluation 01/29/2009
17. Texas Workers' Compensation Work Status Report 01/21/2009, 12/05/2008, 10/15/2008, 08/20/2008



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18. Preauth request 01/09/2009, 11/10/2008, 10/23/2008
19. letter 01/29/2009
20. letter 01/28/2009
21. Medical evaluation 01/21/2009
22. letter 10/29/2008
23. Consultation 10/27/2008
24. Psychological evaluation 10/05/2008
25. Functional capacity evaluation 09/16/2008
26. Computerized spinal range of motion exam 09/05/2008
27. MRI lumbar spine w/o contrast 09/03/2008
28. Initial report
29. Spirograph chart undated
30. Medical note 01/23/2009, 12/22/2008, 11/24/2008, 10/17/2008, 09/29/2008
31. Prescription 12/12/2008, 12/05/2008, 11/05/2008, 10/15/2008, 09/17/2008, 08/19/2008
32. Therapy notes 12/22/2008, 12/17/2008, 12/15/2008, 12/12/2008, 12/10/2008, 12/08/2008, 11/21/2008, 11/19/2008, 11/05/2008, 11/03/2008, 10/30/2008, 10/15/2008, 10/01/2008, 09/26/2008, 09/24/2008, 09/19/2008, 09/15/2008, 09/08/2008, 09/05/2008, 09/03/2008, 09/02/2008, 08/29/2008, 08/27/2008, 08/26/2008, 08/25/2008, 08/22/2008, 08/21/2008, 08/19/2008, 08/18/2008, 08/15/2008, 08/14/2008
33. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

A xx-year- who sustained a work-related injury on xx/xx/xx, involving the lumbar spine secondary to a lifting-type mechanism. Subsequent to the injury, claimant underwent conservative treatment consisting of physical therapy (ultrasound/muscle stimulation, interferential stimulation, intersegmental traction, hydromassage), medication management, and instruction in a home exercise program. This claimant's main complaint appears to be constant low back pain with radiation to the left lower extremity rated at a score of 6 out of 10. Patient has associated numbness and tingling in the left lower extremity on a daily basis with prolonged walking, sitting, and lying flat. None of this is reportedly relieved with medication. Lumbar MRI performed on September 3, 2008, revealed mild lower lumbar facet degeneration; otherwise, normal lumbar MRI. A functional capacity evaluation completed on September 16, 2008, revealed that claimant was currently placed at a PDC of light, which did not mean his work requirement of heavy. Patient approved and placed, via peer review, in a work-hardening program for approximately 80 hours in October 2008.

Current medication management consists of Neurontin and Mobic. Designated doctor evaluation performed on January 21, 2009, by, D.O. Diagnosed claimant with lumbar sprain/strain and sciatica, left leg. He anticipated that claimant would reach maximum medical improvement in approximately three months (April 2009).

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



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After review of the information submitted, the previous nonauthorization for outpatient diagnostic left L5 selective nerve root injection has been upheld because of lack of current available relevant clinical information in support of the application, particularly no information regarding the presence of significant objective radiculopathy on the information submitted, although the patient seems to have subjective symptoms indicative of radiculopathy. In addition, reported lumbar MRI did not reveal any significant disk herniation, nerve root compression, or foraminal stenosis.

The requested intervention does not meet the criteria according to Official Disability Guidelines: Radiculopathy must be documented by physical examination and collaborated by imaging studies and/or electrodiagnostic testing. Therefore, in accordance with Official Disability Guidelines, the recommendation is to uphold previous nonauthorization.

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



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FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)