



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

DATE OF REVIEW: 11/10/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left SI joint steroid injection w anesthesia

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 10/23/2009
2. Notice of assignment to URA 10/23/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 10/22/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 10/21/2009
6. letter 10/16/2009, 10/05/2009
7. Pre-auth request 09/30/2009, medical note 09/22/2009, 06/16/2009, 01/26/2009
8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

Patient is status post injury from xx/xx/xx. Patient still has low back pain that is 7 on a scale of 0-10. On physical exam, there is lumbar tenderness and sacroiliac joint tenderness, right greater than left. Patient has positive Patrick sign, and straight leg raise is negative. The diagnosis is ankylosing spondylitis. Treatment has been with epidural steroid injections, facet injections, and a spinal cord stimulator in place that helps with the leg pain. Patient is on Neurontin, trazodone, and Lidoderm.

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

The determination is upheld. Referring to the Official Disability Guidelines' chapter on hip, under criteria for sacroiliac blocks, states that the history and physical should suggest the



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diagnosis of sacroiliac joint disease with at least three positive exam findings. As listed above, there is only one positive exam finding, which was the positive Patrick test. The records reviewed do not support the medical necessity of the request therefore this is denied.

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)