



Medwork Independent Review

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

04/12/2010

DATE OF REVIEW: 04/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural steroid 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 03/24/2010
2. Notice of assignment to URA 03/24/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 03/24/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 03/05/2010
6. HDI letter 03/03/2010, 02/17/2010, medical note 03/01/2010, 02/11/2010, 02/04/2010, 02/02/2010, 01/29/2010, 01/25/2010, 01/20/2010, 01/14/2010, 01/06/2010, 12/29/2009, 12/04/2009, 12/03/2009, order 11/13/2009, medical note 11/10/2009, radiology 11/20/2009, DD exam 11/18/2009, medical note 10/28/2009, 10/22/2009, radiology 10/15/2009, 09/17/2009, OP records 08/04/2009, medical note & labs 07/30/2009, PT re-eval 06/07/2009, DD exam 05/28/2009, medical note 04/24/2009, PT initial eval 03/13/2009, medical note 01/14/2009, 01/07/2009, 01/05/2009, 11/10/2008, DD exam 10/03/2008, radiology 06/10/2008
7. Physician record 08/18/2009, 07/17/2009, 06/25/2009, 06/01/2009, 05/26/2009, 05/13/2009, 04/20/2009, 04/13/2009, 03/04/2009, 02/23/2009, 01/28/2009, 01/12/2009, 12/05/2008, 12/01/2008, 11/19/2008, 11/14/2008, 11/10/2008, 10/31/2008, 10/16/2008, 10/07/2008, 09/15/2008, 08/06/2008, 07/17/2008, knee flow sheet 06/09/2009 – 07/01/2009, daily flow sheet 02/23/2009 – 07/01/2009, TDI forms 06/10/2008 – 02/24/2010
8. ODG guidelines were provided by the URA



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PATIENT CLINICAL HISTORY:

Medical notes state the patient has low back pain that radiates into the legs, left greater than right. The pain is 8 on a scale of 0-10. On physical exam, there is decreased range of motion and tenderness in the low back. Motor and sensory are within normal limits. Straight leg raises are negative. MRI from September 17, 2008, shows disk desiccation with disk bulge at L3-L4, L4-L5, and L5-S1. Patient is on Lyrica. Patient has had treatment with physical therapy, medications, and a TENS unit. The question now is if a lumbar epidural steroid injection medically necessary?

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

Refer to the Official Disability Guidelines' chapter on low back pain, states radiculopathy must be documented and corroborated by imaging studies. Patient does not have a positive straight leg raise. The patient does not have a positive EMG showing radiculopathy. The patient does not have an MRI showing any type of nerve root impingement, and there are no motor or sensory deficits. The reviewed documentation does not support the medical necessity of the requested lumbar epidural steroid injection; therefore, the decision is upheld.

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)