



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Network (WCN)

MEDWORK INDEPENDENT REVIEW DECISION (WCN)

DATE OF REVIEW: 02/11/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right L4-L5 & L5-S1 radiofrequency thermocoagulation (64622, 64623)

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 01/25/2010
2. Notice of assignment to URA 01/25/2010
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 01/20/2010
6. letter 01/19/2010, 12/29/2009
7. Appeal rqst 01/06/2010, pre-auth rqst 01/06/2010, letter 01/05/2010, pre-auth rqst 12/28/2009, medical note 01/04/2010, 12/17/2009, electrodiagnostic study 12/09/2009, medical note 11/30/2009, PT plan of care 04/07/2009, PT note 04/03/2009, 04/02/2009, 03/31/2009, 03/27/2009, 03/26/2009, 03/23/2009, 03/19/2009, PT eval 03/19/2009, health history questionnaire 03/19/2009, radiology report 03/30/2009
8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

Patient is status post injury to the low back. Patient still has low back pain that radiates into the buttocks. The pain is 1-2 on a scale of 0-10. Physical exam shows decreased range of motion in



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the low back with pain on extension and flexion. Patient has had a medial branch block on November 23, 2009, that shows 75% pain relief. The facet block was at right L4-L5 and L5-S1.

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

Referring to the Official Disability Guidelines, chapter on low back, it states under facet neurotomy that a confirmatory block should be done before proceeding to the radiofrequency. Records show there was only one block done. The documentation reviewed does not support the medical necessity of the request. The determination 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)