



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

DATE OF REVIEW: 01/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left L5-S1 ESI

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 12/29/2009
2. Notice of assignment to URA 12/29/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 12/23/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 12/22/2009
6. letter 12/14/2009, 12/09/2009, 11/30/2009
7. Peer review 12/09/2009, pre-auth rqst 12/08/2009, peer review 11/25/2009, medical note 11/18/2009, fax rqst 11/18/2009, radiology report 11/11/2009, medical note 11/04/2009, lab 10/17/2008, radiology report 10/18/2008, OP report 08/09/2007, medical note 08/09/2007, 07/17/2007, radiology report 03/23/2007
8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

The claimant is a female who sustained a work-related injury on xx/xx/xx. Subsequent to the injury, claimant underwent a lumbar microdiscectomy in 1999. Patient currently, since then, has a working diagnosis of chronic low back pain. Claimant was recently evaluated with a lumbar MRI with and without contrast performed on November 11, 2009, which revealed small herniation and posterior hypertrophy resulting in moderate central canal stenosis at L4-L5 level, left posterolateral herniation at L2-L3 disk with possible entrapment of the left L2 nerve in the neural foramen, and a grade 1 posterior spondylolisthesis of L5-S1 with shallow left posterior herniation but no evidence of significant stenosis. A review of follow-up note, dated November



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18, 2009, indicated claimant's physical findings are more on the right than the left. Physical exam reveals tenderness and decreased range of motion of the lumbar spine. Straight leg raise testing was a little more positive on the right today than at last visit. Claimant has a little bit more antalgic gait. Lower extremity motor strength, reflexes, and sensation are reported as normal. Current medication profile consists of Norco, naproxen, and Lidoderm patches.

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

After review of the information submitted, previous non-authorization for left L5-S1 epidural steroid injection is upheld. In accordance with Official Disability Guidelines, treatment index, 6th edition, 2008, under low back-epidural steroid injection, radiculopathy must be clearly documented. Objective findings on clinical examination need to be present with unequivocal evidence of radiculopathy. From the submitted documentation, medical necessity of the request could not be established.

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)