



Medwork Independent Review

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

11/04/2010

MEDWORK INDEPENDENT REVIEW DECISION (WCN)

DATE OF REVIEW: 11/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral L4-L5 Transforaminal ESI Outpt (64483 & 64484)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas State Licensed MD Board Certified Orthopedic Surgeon & Spine Surgeon

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 10/18/2010
2. Notice of assignment to URA 10/18/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 10/15/2010
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 10/15/2010
6. letter 10/13/2010, 08/23/2010, medicals 09/23/2010, 07/13/2010, 07/09/2010, 06/29/2010, 06/23/2010, 06/01/2010, 05/06/2010, 04/08/2010, 03/19/2010.
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This patient was involved in an accident on xx/xx/xx. The patient has had previous low back surgery. The patient has had back and leg symptoms. The MRI scan of March 2010, showed a diffuse disk bulge at L4-L5. At that level, there is no significant foraminal narrowing identified. At L5-S1, there is a broad-based diffuse disc bulge. This is to the left of the midline. There is



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some contact with the exiting left nerve root. This claimant underwent an epidural steroid injection at L5-S1. It did not relieve him of symptoms. Review request if for bilateral L4-L5 transforaminal ESI outpt (64483 & 64484).

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

Based on the Official Disability Guidelines and the records reviewed, there is no indication that there is any nerve root compression at the L4-L5 level. In accordance with Official Disability Guidelines, there is insufficient documentation of pathology at L4-L5 to merit the requested bilateral L4-L5 transforaminal ESI outpt (64483 & 64484); therefore, the insurer's decision to deny 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)