



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
Independent.Review@medworkiro.com
www.medwork.org



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

10/21/2010

DATE OF REVIEW: 10/21/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Caudal ESI Outpt under Fluoro w/IV Sedation 62311 (77003npr)

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 10/04/2010
2. Notice of assignment to URA 10/04/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 10/01/2010
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 09/30/2010
6. letter 09/15/2010, 09/08/2010, Medicals 08/23/2010, 08/10/2010, 08/04/2010, 07/07/2010, 06/21/2010, 06/16/2010, 06/07/2010, 05/17/2010
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

A male who sustained a work-related injury on xx/xx/xx, involving the lumbar spine secondary to a lifting type mechanism. Working diagnosis of mechanical low back pain syndrome, lumbar facet syndrome, rule out lumbar radiculopathy and moderate reactive depression/anxiety secondary to chronic pain state. Following the claimant's accident he underwent conservative treatment with unsustained relief. The patient is complaining of persistent low back pain despite completing appropriate conservative treatment. Lumbar MRI, which revealed at the L4-5 level disk degeneration, disk bulge,



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and facet hypertrophy with mild central spinal stenosis; L5-S1 level, moderate to severe disk degeneration, disk bulge, and facet hypertrophy with spinal stenosis and bilateral foraminal stenosis. Plain films of the lumbar spine, revealed mild degenerative spondylosis at L5-S1, moderate degenerative facet joint hypertrophy at L4-5 and L5-S1 levels. Initial physical examination of the lumbar spine by the requesting provider revealed exquisite tenderness over the right lumbar facet regions, antalgic gait with sidebending and extension, moderate right sciatic notch tenderness; tenderness over the right PSIS with a positive Patrick test on the right; straight leg raising with 60 degrees on the left and 70 degrees on the right with notable hamstring tightness with reproduction of axial back pain only. Motor and sensory testing was unremarkable. Moderate pain on extension at 60 degrees. Trigger point tenderness throughout the lumbar spine noted. EMG nerve conduction study submitted for review, revealed bilateral S1 lumbar radiculopathy; no NCV evidence of generalized peripheral neuropathy or entrapment. The review request is for lumbar caudal ESI outpatient under fluoro w/IV sedation 62311 (77003npr).

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

In accordance with Official Disability Guidelines and the records submitted for review, the insurer's decision to deny is upheld. The criteria to proceed with epidural steroid injections states unequivocal evidence of radiculopathy must be documented by physical examination and collaborated by imaging studies and/or electrodiagnostic testing. Lumbar MRI submitted for review did not reveal any significant disc herniation, spinal canal stenosis and/or nerve root compression. EMG nerve conduction studies submitted did not correlate with physical examination and/or imaging study. There was a lack of available relevant clinical information in support of the requested lumbar caudal ESI outpatient under fluoro w/IV sedation 62311 (77003npr), particularly no information regarding the presence of significant objective radiculopathy exists in the notes submitted; therefore, the 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 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



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- 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)**