



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)*

**04/06/2011**

**DATE OF REVIEW: 04/6/2011**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Outpatient repeat right L4-5 & L5-S1 transforaminal epidural steroid injection w fluoroscopy (64483, 64484, 77003, 99144)

**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 03/21/2011
2. Notice of assignment to URA 02/28/2011 03/21/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 03/18/2011
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 03/17/2011
6. letter 03/22/2011, 03/16/2011, 02/28/2011, medicals 02/17/2011, 02/10/2011, 01/20/2011, 09/11/2010, 07/27/2010, 03/30/2010, 02/04/2010, 11/30/2009, 02/18/2008, 10/24/2004, 10/14/2004, 08/10/2004, 06/16/2004, 05/12/2004, 05/05/2004, 02/13/2004, 01/13/2004, 01/07/2004
7. ODG guidelines were provided by the URA

**PATIENT CLINICAL HISTORY:**

The patient has an injury date of xx/xx/xx. The patient has a history of low back pain that radiates into the legs. On physical exam, there is tenderness, decreased range of motion, and positive straight leg raise. Patient has had previous epidural injections, but there is no documentation of any percentage pain relief. Review request is for an outpatient repeat right L4-



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5 & L5-S1 transforaminal epidural steroid injection w fluoroscopy (64483, 64484, 77003, 99144).

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

Referring to the recommendations of the Official Disability Guidelines' chapter on low back pain, under epidural steroid injections, under number 7, it states that patients in the therapeutic phase should have greater than 50% pain relief for repeat injections to be done. The records provided do not show documentation of this. The documentation submitted for review along with the ODG guidelines does not support the requested outpatient repeat right L4-5 & L5-S1 transforaminal epidural steroid injection w fluoroscopy (64483, 64484, 77003, 99144); 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 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
- 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)