



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

Amended: November 29, 2011

Date: November 28, 2011

DATE OF REVIEW: 11/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The determination of services, ESI L ¾.

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 11/14/2011
2. Notice of assignment to URA 11/14/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 11/10/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 11/02/2011
6. Information on appeal 11/17/2011, 11/10/2011, Result Report 11/02/2011, Medicals 11/02/2011, 11/01/2011, 10/27/2011, 10/25/2011, 10/24/2011, Insurance 10/27/2011, Diagnostic procedures 10/21/2011, Medicals 10/20/2011, 10/13/2011, 10/11/2011, Insurance documents 10/11/2011, Diagnostic procedures 10/05/2011, Medicals 10/04/2011, 09/27/2011, 09/26/2011, 09/21/2011, 09/19/2011, 09/15/2011, 09/08/2011, 09/01/2011, Report Details 08/31/2011, Medicals 08/29/2011, 08/28/2011.
7. ODG guidelines were not provided by the URA



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PATIENT CLINICAL HISTORY

The patient is a male. Initial records submitted were from a Orthopaedic Center . These were physical therapy records. Diagnoses included lumbar HNP, sciatica, and spondylosis. This was the therapy discharge summary from fall 2011. The October 24, 2011, dated note from Dr. was reviewed, as were other provider records. The patient is noted to have sustained a lumbar strain with disk herniation and "associated right leg radiculopathy when he injured his back at work on xx/xx/xx." Treatment had included activity modification, medications, and therapy. The exam findings included loss of lordosis, paraspinal muscle tenderness, right-sided positive straight leg raise along with 4/5 strength "with paresthesias in the right L4 distribution, otherwise 5/5 with full sensation to light touch in the bilateral L2-S1 distributions, 2/4 bilateral patellar and Achilles reflexes."

The patient was at that time considered for therapy among other forms of treatment.

The October 27, 2011, dated denial letter with regard to an L3-L4 epidural steroid injection with fluoroscopy was reviewed. It was noted that the September 1, 2011, dated MRI failed to reveal any significant evidence of neural compression, and the physical exam findings did not reveal significant motor or neurologic deficits.

There were documents which included the MRI findings from September 1, 2011. It was noted that at L3-L4 there was a small, central annular tear and a "small central disk protrusion/herniation is seen at L3-L4...mild disk bulging and degenerative spurring is seen, extending into the neural foramina bilaterally, causing mild bilateral foraminal compromise. Mild facet degeneration is seen at L3-L4 with mild ligamentum flavum hypertrophy...resulting in a borderline focal stenosis at L3-L4."

There was a small central disk bulge at L4-L5 without definite focal disk herniation, canal compromise, or foraminal compromise. Facet degeneration was noted. At L5-S1, a small central and slightly left-sided disk protrusion herniation was seen at L5-S1 with an annular tear. There was minimal facet degeneration noted.

The prior record dated xx/xx/xx, from Dr. discussed a CT scan result from an outside facility that was reviewed, revealing L3-S1 DDD with spondylosis and a probable acute L5-S1 HNP. That was the point in time in which an MRI was felt indicated.

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

The patient does have reasonable documentation of objective evidence of radiculopathy, most recently noted on October 24, 2011, with a combination of the subjective complaints of back pain and right leg radiculopathy along with objective findings of positive straight leg raise on the right and 4/5 strength with paresthesias in the right L4 distribution. This correlates with the MRI findings as noted above, reflecting a central disk herniation with stenosis at the L3-L4 level. Therefore, with the failure of reasonable less invasive options, including medications and



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therapy, and with the correlation between the objective findings on examination and the MRI, at this time, the Official Disability Guidelines do, indeed, support the proposed epidural steroid injection at the L3-L4 level. Applicable Official Disability Guidelines do support one therapeutic epidural steroid injection when there are "objective findings on examination...must be corroborated by imaging studies and/or electrodiagnostic testing...initially unresponsive to conservative treatment...should be performed using fluoroscopy..." Therefore, at this time, the proposed L3-L4 procedure is reasonable and necessary utilizing fluoroscopy as per applicable Official Disability Guidelines for epidural steroid injections.

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)