



Medwork Independent Review

5840 Arndt Rd., Ste #2
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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

Workers' Compensation Health Care Network (WCN)

January 27, 2012

DATE OF REVIEW: 1/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Is the procedure, third lumbar epidural steroid injection, regarding L5 radiculopathy, L5-S1 lumbar disk herniation and lumbar strain deemed medically necessary for this patient?

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 [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]

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 1/10/2012,
2. Notice of assignment to URA 1/6/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 1/10/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 1/09/2012
6. Outpatient letter 1/03/2012, work comp surgical procedures 12/29/2011, outpatient letter 12/23/2011, medicals 12/14/2011, 11/16/2011, operative report 11/01/2011, medicals 10/19/2011, 9/28/2011, 9/14/2011, 8/18/2011, operative report 8/1/2011, medicals 7/20/2011, therapy discharge note 7/18/2011, medicals 6/22/2011, 6/17/2011, patient report 6/17/2011, medicals 6/1/2011, 5/23/2011, additional patient notes.
7. ODG guidelines were not provided by the URA



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PATIENT CLINICAL HISTORY:

The patient is a male who has a lumbar strain and disk herniation that he sustained in xx/xx/xx. Despite work restrictions, medications, therapy, and two epidural steroid injections "which initially helped...his pain has returned. Currently he is having constant, moderate, low back and associated right leg pain."

The patient is also noted to have paresthesias in the right L5 distribution. Positive straight leg raise is noted on the right. There is noted to be grade 5/5 motor power and "full sensation to light touch in the bilateral L2 through S1 distributions/2/4 patellar bilateral and patellar Achilles reflexes." The impression is that of right L5 lumbar radiculopathy, L5-S1 disk herniation, and lumbar strain, and there was a consideration for a "third ESI."

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

Despite the patient's low back and right leg pain, full sciatica with paresthesias, the patient has not demonstrated *Official Disability Guidelines'* associated positive/adequate responses to the prior epidural steroid injections. Applicable *Official Disability Guidelines* support an additional epidural steroid injection when prior injections, especially the most recent one, have documented 50%-plus pain reduction and functionality improvement over a 6- to 8-week period. In addition, most recently, with the unremarkable sensory, motor, and reflex examination, despite the sciatica with intermittent paresthesias, objective evidence of radiculopathy is not documented. Without objective evidence of radiculopathy and without guideline criteria being met with regard to the prior epidural steroid injection response/outcomes, a third epidural steroid injection is not reasonable or necessary at this time as per applicable *Official Disability Guidelines*; therefore the insurer's denial 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)**