



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

Workers' Compensation Health Care Non-network (WC)

December 27, 2011

DATE OF REVIEW: 12/26/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Is the right L4-L5/L5-S1 rhizotomy 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 DO Board Certified Physical Medicine & Rehab physician

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 12/12/2011,
2. Notice of assignment to URA 12/07/2011,
3. Confirmation of Receipt of a Request for a Review by an IRO 12/12/2011,
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 12/08/2011,
6. Legal documents 12/07/2011, information from health direct 12/01/2011, 11/07/2011, follow-up information 10/28/2011, evaluation 10/28/2011, 09/29/2011, 09/08/2011, 08/08/2011, medicals 06/21/2011, 06/07/2011, 05/24/2011, 05/22/2011, 05/17/2011, 04/04/2011, 03/08/2011.
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

The claimant is a female who sustained an occupational slip-and-fall injury on ice dated xx/xx/xx. She remained symptomatic with low back pain and lower extremity radicular pain.



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Therefore, the claimant underwent a June 7, 2011, lumbar MRI scan demonstrating L5-S1 degenerative disk disease and minimal posterior annular bulging. No other significant findings are noted and the facet joints are found to be normal. The claimant underwent bilateral L4-L5 and L5-S1 diagnostic medial branch blocks under fluoroscopy on October 7, 2011. At the physician follow-up visit of October 28, 2011, the claimant kept a pain diary as instructed, and her pre-procedure pain level of 6/10 to 7/10 was reduced to 2/10 for 30 minutes to 2 hours post-procedure and continuing for 8 hours to 5 days after the procedure where her pain score ranged from zero to 1 on a scale of 10. Reportedly post-procedure, the claimant went to a shopping mall for 4 hours of walking with associated bending and noted a pain level of 1 on a scale of 10. The claimant is also continuing to engage in occupational duties. The October 28, 2011, follow-up examination of the claimant demonstrates no focal lower extremity impairment. The claimant demonstrates no focal lower extremity neurologic impairment. There is reported lumbosacral spine tenderness with increased pain with range of motion. However, there is no documented recurrent facetogenic lumbar spine pain. Additionally, there is no documented evidence of a reduction in analgesic medication use.

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

The requested right L4-L5/L5-S1 rhizotomy procedure is not medically necessary for the claimant because this request fails to satisfy Official Disability Guidelines, which require continuing clinical evidence of lumbar spine facet-mediated pain and because the diagnostic lumbar facet injections provided a longer duration of reported benefit than expected, which would indicate a degree of placebo effect. The true therapeutic benefit of the October 7, 2011, diagnostic medial branch blocks is questionable, therefore the requested L4-L5/L5-S1 rhizotomy 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



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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)**