



Medwork Independent Review

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

February 28, 2012

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 2/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar: bilateral transforaminal epidural steroid injection at L5-S1

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 [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. Assignment to 2/13/2012,
2. Notice of assignment to URA 2/10/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 2/13/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 2/13/2012
6. URA information 2/09/2012, preauthorization sheet undated, insurance letter 2/08/2012, preauthorization 2/02/2012, URA information 2/01/2012, insurance information 2/01/2012, medicals undated, insurance information 1/31/2012, preauthorization information 1/26/2012, URA Information 1/26/2012, medicals undated, TX workers comp information 1/13/2012, visitation summary 1/13/2012, medicals 12/13/2011, radiology report 9/29/2011, preauthorization information 8/05/2011, URA information 8/05/2011, medicals 8/04/2011, imaging information 7/29/2011, preauthorization information 7/11/2011, URA information 7/08/2011, medicals 6/29/2011, 6/02/2011.
7. ODG guidelines were not provided by the URA



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PATIENT CLINICAL HISTORY:

The patient is a male with a history of low back pain that radiates into the left buttock and hip. On physical exam there is tenderness with decreased range of motion. Motor, sensory, and reflexes are within normal limits. Pain is 6 on a scale of 0-10. MRI shows annular tear and a disk protrusion at L5-S1.

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

In reference to the *Official Disability Guidelines*' chapter on pain on low back pain under epidural steroid injections, it states that radiculopathy must be documented. There is no documentation of radiculopathy by EMG. There is no documentation of sensory or motor deficits; therefore, the insurer's denial is not medically necessary and 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)