Medwork Independent Review
5840 Arndt Rd., Ste #2
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1-800-426-1551 | 715-552-0746
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ACCREDITED INDEPENDENT REVIEW ORGANIZATION

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

DATE OF REVIEW: 3/12/2012
IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Left L2-3 and Left L3-4 transforaminal epidural steroid injection.

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 2/29/2012,
2. Notice of assignment to URA 2/28/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 2/29/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 2/28/2012
6. Letter from Attorney 3/5/2012, 2/28/2012, Insurance information 2/10/2012, Medical information 2/7/2012, Insurance information 1/30/2012, Medical information 1/26/2012, workers compensation status report 11/9/2011, Medical information 11/9/2011, 10/18/2011, workers compensation status report 10/17/2011, Medical information, 10/4/2011, 10/3/2011, workers compensation status report 9/30/2011, Medical information 9/27/2011, 9/26/2011, workers compensation status report 9/22/2011, Insurance information 9/20/2011, Medical evaluations 9/19/2011, Physical therapy report 9/13/2011, Medical information 9/13/2011, report of injury 9/8/2011.

PATIENT CLINICAL HISTORY:
The patient is a male who was evaluated for an injury that he sustained when unloading heavy boxes of copper wire that reportedly weighed 30 to 40 pounds on a repetitive basis on xx/xx/xx. The findings concluded that the individual complained of low back and left thigh pain with radiation up to the interscapular area. The exam findings revealed that the patient was noted to have left lumbar spasm with guarding and loss of lordosis. Straight leg tests were negative.

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Reflexes were intact in knees and ankles. Motor power was grade 5/5, and sensation was intact. The initial working diagnosis was "lumbar strain and low back pain aggravation from repetitive heavy lifting." Despite a course of restricted activity, non-steroidal anti-inflammatory drugs, and physical therapy, the patient had persistent symptoms. A subsequent MRI was then obtained.

As of September 26, 2011, it was noted that the patient had diagnoses of low back sacroiliac joint strain and low back pain and was prescribed a sacroiliac joint injection, muscle stimulation, and a TENS unit, along with restricted activities. The treatments as above were then noted to have occurred, and it was noted on October 3, 2011, in follow-up by the provider that the MRI scan did not reveal any signs of herniated disk. It was noted that the lower back "strain and SI joint strain is most likely a result of the injury, but he has underlying degenerative changes in the lumbar spine that are most likely aggravating the overall situation."

It was noted that the MRI from September 27, 2011, revealed "minimal disk bulges, ligamentum flavum hypertrophy, and facet hypertrophy at all of the lumbar levels." The impression was low back pain, sacroiliac joint dysfunction, and possibly some discogenic pain. The subsequent records were reviewed, and the patient was considered for epidural steroid injections as noted above.

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

With low back pain with radiation into the thigh and without examination findings compatible with any radiculopathy (normal straight leg raise, motor power in the lower extremities, sensation and reflexes in lower extremities) along with the lack of imaging study supporting any nerve root impingement, at this time, applicable *Official Disability Guidelines* do not support the proposed epidural steroid injection(s). Without clinical objective findings compatible with radiculopathy, with supporting electro diagnostics and/or imaging studies, this patient does not have a medical reasonable indication for the proposed request as per applicable *Official Disability* Guidelines' criteria at this time; 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 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**

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- ☐ **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)**