



Medwork Independent Review

5840 Arndt Rd., Ste #2
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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

DATE OF REVIEW: 11/05/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right L3-L4 and L4-L5 facet injections.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas State Licensed MD Board Orthopedic 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. Dept of Insurance Assignment to Medwork 10/16/2013,
2. Notice of assignment to URA 10/9/2013,
3. Confirmation of Receipt of a Request for a Review by an IRO 10/16/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 10/15/2013

Letter to physician from insurance plan 9/6/2013, 8/26/2013, peer review report 8/23/2013, work comp verification for diagnostic/surgical procedures 8/21/2013, office visit records 8/20/2013, 7/11/2013, 7/3/2013, operative report 5/29/2013, summary notes 5/10/2013, electromyography report 5/10/2013, medical notes 5/10/2013, commissioner order 4/10/2013, medical notes 4/3/2013, request for designated doctor examination 3/11/2013, medical notes 6/29/2012, 6/27/2012, 6/26/2012, 6/25/2012, 6/22/2012, 6/21/2012, 6/20/2012, 6/19/2012, 6/14/2012, 6/13/2012, 6/12/2012, 6/11/2012, 6/8/2012, 6/7/2012, 6/6/2012, 6/5/2012, 6/4/2012, 6/1/2012, 5/31/2012, 5/30/2012, 5/8/2012, 5/3/2012, 5/2/2012, 4/30/2012, 4/27/2012, 4/25/2012, 4/23/2012, 4/20/2012, 4/18/2012, 4/17/2012, 4/13/2012, 4/4/2012, 4/2/2012, 3/5/2012, operative report 2/23/2012, x-ray report 2/23/2012, medical notes 1/30/2012, operative report 1/10/2012, medical notes 1/6/2012, 12/13/2011, 12/12/2011, 12/9/2011, 12/7/2011, 12/6/2011, 12/2/2011, 11/30/2011, 11/28/2011, 11/25/2011, 11/23/2011, 11/21/2011, 11/18/2011, 11/2/2011.



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PATIENT CLINICAL HISTORY:

The patient was injured on xx/xx/xx. The patient was treated for his back condition medically, and then surgically, he is status post laminectomies at both L3-L4 most recently in February 2012 and L4-L5 in early 2001. The patient is also status post treatment with medications, along with an epidural steroid injection, the latter as of January 2012.

The records from the treating provider have been reviewed. The records also reveal that an MRI from June 14, 2012, revealed post discectomy scarring and no evidence of recurrent disk herniations and mild facet arthrosis at L3-L4 and L4-L5. The electrical studies from May 9, 2013, revealed a mild, chronic L4-L5 radiculopathy with minimal acute characteristics and a chronic L4-L5 radiculopathy with mild acute changes bilaterally, as noted above, along with right-sided S1 radiculopathy.

The patient also underwent an epidural steroid injection on May 28, 2013.

The electrical studies of June 19, 2013, revealed mild, chronic, right L5-S1 radiculopathy. The clinical notes, including from the summer 2013, including August 20, 2013, discuss low back and right leg pain.

The repeat laminectomy on the right side at L3-L4 was reportedly performed on February 23, 2012. It indicates a history of a staph infection after the second laminectomy, that being after the laminectomy in February 2001. The laminectomy on February 23, 2012, was at L3-L4, and actually was only the initial and only laminectomy at that level.

The patient has been noted to have right-sided lumbar paraspinal rigidity, positive straight leg raise, positive FABER maneuver, and an intact neurologic exam. The patient was considered for diagnostic and plausibly therapeutic facet injections at L3-L4 and L4-L5.

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

The patient has at least radiculitis and plausible ongoing electrodiagnostically associated chronic radiculopathy. Facet injections are not supported by clinical guidelines in the presence of radiculitis/chronic radiculopathy, as per guidelines for same. Therefore, at this time, the previous denials for the requests are upheld based on the *Official Disability Guidelines*, low back chapter, facet joint injection criteria for facet-mediated pain.



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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
- 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)