



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

DATE OF REVIEW: 9/25/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural steroid injection L5/S1 on left

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

Texas State Licensed MD Board Certified Anesthesiology and Pain Medicine Physician.

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 9/5/2013
2. Notice of assignment to URA 9/3/2013
3. Confirmation of Receipt of a Request for a Review by an IRO 9/5/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 9/4/2013

Letter to physician regarding reconsideration of an adverse determination 8/30/2013, appeal request 8/23/2013, medical documents 8/14/2013, letter regarding authorization 7/31/2013, preauthorization request 7/26/2013, medical documents 7/19/2013, physical therapy daily note 7/5/2013, 7/3/2013, 7/2/2013, follow-up evaluation 6/28/2013, compensation work status report 6/28/2013, physical therapy daily note 6/27/2013, medical documents 6/26/2013, physical therapy daily note 6/26/2013, 6/25/2013, 6/20/2013, 6/19/2013, 6/17/2013, patient information 5/29/2013.

PATIENT CLINICAL HISTORY:

The patient is a male who sustained a work-related motor vehicle accident involving the lumbar spine on xx/xx/xx. Subsequent to failed conservative treatment consisting of physical therapy and medication management, a lumbar MRI was performed on June 26, 2013. This radiographic



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imaging study revealed at the L5-S1 level a grade 1 spondylolisthesis 5-7 mm; bilateral spondylosis with pars defects; 3-mm pseudo-bulge; there was a wide anterior epidural space at this level with no focal effacement of nerve roots, foramen, or thecal sac.

The patient's treating physician, submitted a note on August 23, 2013, which indicated the patient continued with low back pain with radiation down the left lower extremity, at worst 7 to 9 out of 10 without medication, at best zero to 3 out of 10 with medications. Clinical examination reveals straight leg raises positive bilaterally, deep tendon reflexes diminished in the lower extremities, sensory deficits identified in the left L5-S1 dermatomal distribution, and poor toe-and-heel walking. Diagnosis of lumbar radiculopathy provided.

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

After review of the information submitted, to include the mechanism of low-back injury, history, and clinical examination, which revealed associated findings indicative of lumbar radiculopathy, the request for a left L5-S1 lumbar epidural steroid injection is medically approved.

This patient is most likely an outlier to the *Official Disability Guidelines*, but the request is reasonable and appropriate and within the standard of care of treatment and should be certified. The denial of the services is overturned.

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)



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- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**