



Medwork Independent Review

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

Date: May 30, 2013

DATE OF REVIEW: 5/24/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar 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 Orthopedic Surgeon & Spine 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. Texas Dept of Insurance Assignment to Medwork 5/14/2013,
2. Notice of assignment to URA 5/13/2013,
3. Confirmation of Receipt of a Request for a Review by an IRO 5/14/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 5/14/2013

Adverse determination of appeal/reconsideration notification from mcmc 5/7/2013, physician review recommendation 5/7/2013, denial determination notice from mcmc 4/29/2013, preauthorization request for outpatient procedure 4/29/2013, preauthorization request for outpatient procedure 4/25/2013, patient profile 4/25/2013, case report from mcmc 4/25/2013, medical information 4/23/2013, electro-diagnostic testing consent form 4/23/2013, patient information 4/23/2013, medical information 4/22/2013, 4/11/2013, workers comp verification 4/3/2013, medical notes from preferred imaging 4/1/2013.

PATIENT CLINICAL HISTORY:



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The patient is noted to have a clinical history of low back pain with radiation into the lower extremities. The most recent clinical documentation from the treating provider's office documented decreased sensation, although non-dermatomal, in the lower extremities, along with decreased motor power at the level of thigh flexion. Otherwise motor power was noted to be intact. There was noted to be diminished Achilles reflexes bilaterally as noted on 04/22/2013 and the most recent 04/11/2013 in the records submitted for review. The electrodiagnostics revealed L5 radiculopathy. The MRI of the lumbar spine from 04/01/2013 revealed a "disk extrusion at L5-S1" as noted on 04/23/2013 and even more recent provider records. The electrical studies specifically reviewed were noted to reveal the "acute left L5-S1 radiculopathy" and were dated 04/23/2013. The MRI scan was specifically reviewed in addition by this reviewer.

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

The documentation does describe in particular due to the diminished Achilles reflexes, but also to a lesser degree, attributable to the nondescript decreased sensation and the positive straight leg raise on the left, evidence of objective radiculopathy on clinical examination. It is corroborated by the MRI findings of the abnormal disk extrusion at L5-S1 and to a lesser degree the electrodiagnostics, with the acute radiculopathy at L5-S1. The patient has been documented to have undergone treatment with numerous medications and restricted activities, and the critical condition has persisted despite being the reasonable non-operative treatments administered. Therefore the applicable clinical guidelines including from ODG lumbar spine chapter regarding epidural steroid injections do support the administration of a lumbar epidural steroid injection as being fully medically reasonable and necessary at this time.

The denial of these services is overturned.



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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)