



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

Date: July 23, 2013

DATE OF REVIEW: 7/22/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Caudal epidural steroid injection with catheter lysis of adhesion under fluoroscopy and IV sedation, level 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 Physical Medicine and Rehabilitation.

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 7/3/2013,
2. Notice of assignment to URA 7/3/2013,
3. Confirmation of Receipt of a Request for a Review by an IRO 7/3/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 7/3/2013

Carrier submission 7/10/2013, requested services from insurance plan 7/1/2013, preauthorization form 6/19/2013, follow-up notes 6/10/2013, medical notes 6/4/2013, requested services from insurance plan 5/22/2013, preauthorization form 4/30/2013, rehabilitation progress notes 4/23/2013, follow-up notes 4/16/2013, initial pain evaluation 3/15/2013, follow-up notes 12/12/2012, medical notes 11/16/2012, office visit notes 11/14/2012, operative report 11/8/2012, initial comprehensive evaluation 10/29/2012, peer review 2/7/2012, recheck notes 12/23/2011, workers compensation work status report 12/7/2011, 11/29/2011, medical notes 11/28/2011, recheck notes 11/28/2011, recheck notes 11/25/2011, workers compensation work status report 11/23/2011, 11/20/2011, 11/18/2011, 11/8/2011, 11/7/2011, medical notes 11/8/2011, recheck



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notes 11/7/2011, designated doctor evaluation 11/4/2011, report of medical evaluation 11/4/2011, amendment to doctor evaluation 11/4/2011, recheck notes 11/1/2011, peer review addendum 10/29/2011, letter of rebuttal 10/24/2011, recheck notes 10/9/2011, medical notes 10/4/2011, consultation 10/3/2011, workers compensation work status report 10/2/2011, 9/27/2011, peer review 9/16/2011, visit history 9/6/2011, medical notes 8/26/2011, medical notes 8/20/2011.

PATIENT CLINICAL HISTORY:

The patient is a male who sustained an occupational lower back injury on xx/xx/xx. He thereby sustained an occupational lower back injury. He has a prior history of a xxxx occupational lower back injury at L5-S1 requiring laminectomy/discectomy. Most recently, the patient underwent a November 8, 2012, L5-S1 pedicle screw fusion. Most recently, the patient is under the care of an anesthesiologist/interventional pain management physician. This physician diagnosed post lumbar laminectomy pain syndrome with recurrent bilateral lumbar radiculopathy, insomnia, and depression. He recommended the caudal epidural steroid injection with catheter lysis of adhesion under fluoroscopy and IV sedation at level L5-S1, as the patient remained unimproved postoperatively.

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

The requested caudal epidural steroid injection with catheter lysis of adhesions under fluoroscopy and IV sedation at level L5-S1 remains non-authorized, because this procedure is not supported by evidence-based peer-reviewed scientific medical literature and therefore is not medically indicated.

The denial of these services is upheld.



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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)