



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

Date: June 17, 2013

DATE OF REVIEW: 6/14/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left L5 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

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

PATIENT CLINICAL HISTORY:

The patient is a male who has had persistent back pain since reporting having injured his back as a result of participating in the lifting. The patient has had diagnostics and treatment including medications, restricted activity, the utilization of a TENS unit and therapy. The patient has been noted to have an MRI from 05/03/2013 revealing a midline disk herniation at L4-5 without apparent nerve root compression. There was also degenerative narrowing at the L5-S1 disk.

The reviewed records include the provider notes that are inclusive of 04/22/2013, among others, revealing that the patient has had persistent low back pain and an intact neurologic examination of the lower extremities. The patient on 05/07/2013 was also noted to have normal reflexes, intact sensation, unremarkable motor power, and a normal gait. The abnormal findings included tender paraspinal muscles with decreased lumbar range of motion and an unremarkable straight leg raise with regard to the lower extremities. The denial letters have revealed the lack of objective evidence of radiculopathy. The appeal letter, including 05/16/2013, was reviewed in addition.

The next set of records included the clinical notes from 05/07/2013 revealing that the patient was



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on light duty and was considered for an epidural steroid injection. The next set of records, include the specific report of the MRI dated 05/03/2013. This was of the lumbar spine, revealing findings as noted above.

There were no other records submitted for review except the therapy records from the spring of 2013 at the Xxxx were reviewed.

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

The patient has been consistently documented to have low back pain, however without any abnormalities of sensation, motor power, reflexes and/or straight leg raise. The MRI does not evidence findings supportive of radiculopathy. Therefore, since there is no evidence of objective radiculopathy as corroborated by either MRI and/or electrical studies as is essentially mandated by the applicable ODG criteria, it is this reviewer's impression that the guideline criteria has not at all been met for the requested lumbar epidural steroid injection. The requested left L5 transforaminal epidural steroid injection is therefore not considered medically reasonable or necessary at this time based on the applicable ODG criteria from the lumbar spine chapter epidural steroid injection section.

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)