



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

DATE OF REVIEW: 7/14/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient repeat transforaminal bilateral 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 Physical Medicine and Rehabilitation and Pain Medicine.

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 6/24/2014,
2. Notice of assignment to URA 6/20/2013,
3. Confirmation of Receipt of a Request for a Review by an IRO 6/24/2014
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 6/24/2014
Notice of utilization review findings 5/19/2014, 4/15/2014, pre-authorization request 4/16/2014, 4/10/2014, patient notes 4/7/2014, 1/7/2014, 12/18/2013, 11/22/2013, 9/30/2013, 8/26/2013, 7/31/2013, 7/27/2013, lumbar notes 2/4/2002.

PATIENT CLINICAL HISTORY:

Claimant continues to deal with radicular symptoms despite having lumbar fusion from 2002 at L4 through S1. He has maintained pain care under the care of his physician, utilizing both analgesics and intermittent injection therapy. The close evaluation note from April 7, 2014, reveals that the claimant's pain had returned for about 4 weeks. This is evidenced by a statement that reads, "This patient is having radicular type pain, unresponsive to conventional noninvasive treatment such as patient, rehabilitation, and the use of medications for more than 4 weeks prior to this 4 weeks he had 80% improvement after transforaminal per documentation." This injection was performed on December 18, 2013. During this timeline, the claimant had over 8 weeks of



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relief before he started having pain 4 weeks prior to the date of April 7, 2014, and as such, puts him within the guidelines for a repeat injection determined per ODG, the maintenance phase of injection therapy. He is clearly past the diagnostic phase.

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

General consensus recommendation is for no more than 4 blocks per region per year. Again, per ODG, it does not appear that he has surpassed this general recommendation. That again is a consensus recommendation. Nonetheless, he has symptoms of radicular pain on the left side and has responded favorably by 80% for over 8 weeks per documentation and he is a candidate for repeat injection phase and repeat injection in the therapeutic phase. This is a partially approved judgment, in that because he has no right-sided symptoms, there is not any reason to perform an epidural steroid injection on the right side from a transforaminal approach. The left side, however, which is the symptomatic side, does meet requirements for injection therapy.

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)