



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

DATE OF REVIEW: 12/29/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left L5 selected nerve injection with fluoroscopy.

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

Texas State Licensed Physical Medicine, Rehabilitation 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.

PATIENT CLINICAL HISTORY:

Electrodiagnostic study dated 08/29/2014 demonstrating normal study of both lower extremities. The MRI of the lumbar spine dated 04/03/2014 revealed dehydration of the L3-4 disk with 1.7 mm disk protrusion of left subarticular recess and left neuroforaminal segmental disk. There is a left subarticular recess and foraminal narrowing present. There is dehydration in the L4-5 disk and 1.8 mm left middle foraminal disk protrusion. The left foraminal stenosis is noted at that level, 1.4 mm left middle foraminal disk protrusion L5-S1. Degenerative annular fissure is noted at this level as well. Per documentation, the claimant has also had a lumbar epidural steroid injection, receiving 80% improvement after this injection. Neurologic exam has revealed subtle motor deficit in left tibialis anterior and left extensor hallucis longus and abnormal sensation to light touch at the L5 and S1 dermatomes.

The patient's current medications include Lyrica, Tylenol, cyclobenzaprine, hydrochlorothiazide, and Mobic.

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

The claimant has failed conservative measures including physical therapy, analgesics, and passage of time for natural tissue healing. Given that the date of injury was xx/xx/xx, natural progression of an injury would have allowed for resolution of symptoms by now. Injection therapy is both diagnostic and



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therapeutic and not if there is a positive response, as in this case it also clarifies the primary pain generator and what would be considered a successful treatment.

In this case, 80% would be considered a successful injection per ODG as well as would be considered improvement from baseline in the community. Electrodiagnostics revealed a normal study, although the special disability guidelines would suggest that because there is no electrodiagnostic evidence of a radiculopathy, the injection would not be considered reasonable or medically necessary; however, clinical examination did reveal loss of sensation in the L5 and S1 dermatomes as there is some subtle weakness in the L5 myotomal muscles. Radicular pain may be chemical in nature and not compressive at times.

In this case, the claimant does have an annular fissure at L5-S1, which could cause a significant chemical radiculitis, not to mention that there is also lateral recess stenosis present on the MRI at the L4-L5 level, which would potentially compress or irritate the descending L5 nerve root. In this scenario, where advanced imaging can correspond to an irritated L5 nerve root as well as failure of treatment to date aside from the previous injection and the improved results with the previous epidural steroid injection. Based on imaging studies, clinical examination, previous response to an epidural steroid injection which had 80% improvement, and failure to improve this injection at L5 nerve root under fluoroscopy, it is considered reasonable and medically necessary.

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 KNOWLEDGBASE
- 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)