



Medwork Independent Review

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MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 6/2/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right L5-S1 Lumbar 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 Anesthesiologist 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.

PATIENT CLINICAL HISTORY:

Right sided L5-S1 lumbar epidural steroid injection has been denied on 2 separate occasions which was requested by the treating physician. The physician claims the treatment is medically necessary for claimant's work and diagnosis of failed back surgery syndrome and lumbar radiculopathy. The insurer states that the treatment does not meet the criteria for medical necessity to proceed with right-sided lumbar epidural steroid injection, L5-S1 level, for the above condition.

The patient is a male who sustained a work-related injury on xx/xx/xx, secondary to lifting type mechanism. Subsequent to the injury, claimant diagnosed with lumbar radiculopathy. Following failed conservative treatment, claimant underwent a right L5-S1 hemilaminectomy and microdiscectomy performed on May 21, 2013. Subsequently to continued pain, patient underwent L5-S1 lumbar laminectomy and discectomy. It looks like July 10, 2014.

There have been no additional post-surgical radiographic imaging studies submitted for review. Notes indicate claimant underwent lumbar epidural steroid injection performed in the past with suboptimal relief. Patient continues to suffer from chronic low back pain and psychosocial issues as related to his pain.



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Last minute notes, on further examination of the lumbar spine provided by the treating physician, indicate straight leg raise positive on the left; diminished deep tendon reflexes, lower extremities; range of motion diminished, flexion extension; sensory deficit right L5-S1 dermatome distribution. Additionally, there has been documentation indicating psychological evaluation for patient pending a lumbar spinal cord stimulator trial.

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

There was a lack of available relevant clinical information in support of the application, particularly no information regarding the presence of significant, objective radiculopathy pertaining to sensory, motor, or reflex deficits in the lower extremities. There was documentation supporting the fact that there was no clinical benefit from previous individual pain management injections performed in the past for this claimant. ODG requires for additional objections, there should be documentation of at least 50% to 70% relief of pain from baseline and evidence of improved function for at least the 6-8 weeks following delivery. Documentation of benefit should include duration of relief, degree of decreased use of medications, and the possibility of return to work. Given the above information, subsequently the requested service of right side lumbar epidural steroid injection has been denied.

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)