



Medwork Independent Review

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MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 03/25/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right-sided lumbar epidural steroid injection, L5-S1 level. RO determination of the upheld previous non-certification right sided lumbar epidural steroid injection L5-S1 level.

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

Texas State Licensed MD Board Anesthesiology 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:

The patient is a male who sustained a work-related injury on XX/XX/XX involving the lumbar spine with radiation to the left lower extremity. Following failed conservative treatment, lumbar MRI performed on XX/XX/XX, which revealed left posterolateral disk herniation, 4 mm, L2-3 levels; L4-5 paracentral disk herniation to the left, 4.5 mm with impression of a thecal sac and with moderate neuroforaminal encroachment, L5-S1 level, large extruded disk herniation, seemed essentially on to the left of the midline predominantly.

The patient has undergone intervention steroid injections i.e., lumbar Pitocin injection, L5-S1 level, XX/XX/XX and XX/XX/XX. Office note submitted by the requesting physician dated XX/XX/XX reveals continued low back pain with radiation to the left lower extremity; no significant physical examination findings documented.

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

Submitted follow-up notes did not provide any information regarding the presence or absence of sensory, motor or reflex deficits in the lower extremities or any other associated findings indicative of lumbar radiculopathy. Therefore, due to the lack of available relevant clinical previous information in support of the request, the previous denials to proceed with right-sided lumbar Pitocin injection L5-S1 level has been upheld.



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The request submitted does not meet the criteria for conservation of lumbar Pitocin injections as per Official Disability Guidelines, Low Back Chapter, epidural steroid injections (ESI), therapeutic.

Of note, corroborating study, lumbar MRI from XX/XX/XX did not reveal any right-sided neuroforaminal or nerve root compression L5-S1 level.

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)