



## Medwork Independent Review

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### *MEDWORK INDEPENDENT REVIEW WC DECISION*

**DATE OF REVIEW:** 01/06/2016

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Right L4-L5, L5-S1 transforaminal ESI with fluroscopy.

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

Texas State Licensed MD Board Orthopedic 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.

### **PATIENT CLINICAL HISTORY:**

The claimant was noted to have been injured in a fall onto the buttocks. The individual has been documented to have persistent low back pain with radiation into the bilateral buttock region. The claimant has been noted to have had the radiation ulcer into be distribution of the coccyx. There has been no evidence of involvement in the left leg and radiation has involved primarily the right leg. The records of XX/XX/XX were reviewed. The individual was noted to have had treatments with medications and therapy along with altered activities. The most recent exam findings have documented that the patient had motor power work intact, although there was some tenderness and decreased range of motion in the lumbar spine. Reflexes were noted to be symmetric and 1+ in the bilateral lower extremities. An MRI dated XX/XX/XX revealed a bulging anulus with fissure at L4-5, along with similar findings at L5-S1. Straight leg raise has been noted to be positive also.

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

The applicable clinical guidelines including ODG for epidural steroid injections indicates that there must typically be expected findings of abnormal sensation, motor and/or reflex examinations in the myotomal and/or dermatomal distributions that corroborates radiculopathy. In addition, clinical radiculopathy must be typically corroborated by imaging and/or electrical studies. In this case there was no evidence of clinical objective radiculopathy at the L4-L5 or S1



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level as corroborated by imaging or electrical studies. Therefore, at this time, the applicable clinical guideline criteria for the request have not been met and the request could not to be considered medically reasonable or necessary at this time.

### **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)