

SENT VIA EMAIL OR FAX ON  
Aug/08/2011

## Pure Resolutions Inc.

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/08/2011

**IRO CASE #:**

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

1 lumbar epidural steroid injection at L5/S1 with Fluoroscopy and Epidurography

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

Board Certified PMR and Pain Management

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

1. Cover sheet and working documents
2. Utilization review determination 07/11/11
3. Utilization review determination 06/30/11
4. Request for treatment authorization form
5. Orthopedic reports Dr. MD 01/12/10 through 07/12/11
6. MRI lumbar spine 10/01/09
7. Operative report 03/28/11
8. Reference material
9. Letter Dr. MD 02/01/11
10. DWC form 69 05/10/11
11. Review of medical history and physical exam 05/10/11
12. Texas Workers' Compensation work status report 05/10/11
13. Notice of assignment of IRO 07/22/11
14. Initial consultation MD 09/16/09
15. MMT/ROM testing 01/12/10 through 05/09/11
16. X-ray right knee 01/12/10
17. MRI right knee 12/03/09
18. X-rays right knee 12/03/09
19. MRI left wrist 10/01/09

20. MRI left hand 10/01/09
21. X-rays left wrist, left hand, and lumbar spine 10/01/09
22. Request for IRO 07/19/11
23. Telephone conference 07/05/11
24. Utilization review acknowledgement of appeal/reconsideration request 07/01/11
25. Utilization review determination 03/18/11
26. Utilization review acknowledgement of appeal/reconsideration request 03/15/11
27. Utilization review determination 02/23/11
28. Operative report 06/02/10
29. Utilization review determination 04/12/10

#### **PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. On this date the patient tripped over a runner and fell forwards, sustaining injuries to her right knee, left wrist, forearm and hand as well as low back. Note dated 09/16/09 reports impression of abrasion of knee, contusion of knee, sprain of wrist and hand, lumbosacral spine sprain and sprain of elbow. MRI of the lumbar spine dated 10/01/09 revealed posterior 7 mm disc protrusion/herniation impinging on the thecal sac at L5-S1 and also on the right more than left S1 nerve roots as they emerge from the thecal sac on each side. No neural foraminal narrowing is present. Treatment to date is noted to include physical therapy, cortisone injections to the right knee, left wrist surgery on 01/13/10, and right knee arthroscopy with debridement of lateral meniscal tear on 06/02/10 and Supartz injections. Peer review dated 02/01/11 indicates that there is no documentation to support additional medications, physical therapy and other medical treatment. The patient subsequently underwent lumbar epidural steroid injection at L5-S1 on 03/28/11. Follow up note dated 04/07/11 indicates that the patient reports 70% relief. Designated doctor evaluation dated 05/10/11 indicates that the patient reached MMI as of this date with 6% whole person impairment. The designated doctor notes that there are no motor or sensory deficits noted and the EMG/NCV of the lower extremities was normal. Orthopedic report dated 06/10/11 indicates that the epidural steroid injection provided approximately 75% relief for approximately 3 months.

Initial request for lumbar epidural steroid injection was non-certified on 06/30/11 noting that there is no clear documentation of decreased need for pain medications and functional response with previous epidural steroid injection. The denial was upheld on appeal dated 07/11/11 noting that the records submitted for review did not contain objective documentation of the failure of trial of conservative treatment. There is no objective documentation regarding sustained pain relief and increase in functional capacity as a result of the previous injection. Electrodiagnostic and imaging studies were not in concordance with a diagnosis of radiculopathy.

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

Based on the clinical information provided, the request for one lumbar epidural steroid injection at L5-S1 with fluoroscopy and epidurography is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of conservative treatment for the low back submitted for review to establish that the patient was initially unresponsive to conservative treatment. There is no documentation of functional improvement or medication reduction secondary to the previous injection. The patient underwent EMG/NCV which is reported to be a normal study. Given the current clinical data, the requested epidural steroid injection is not indicated as medically necessary.

#### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

**[ X ] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES