

Pure Resolutions LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/03/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Lumbar Epidural Steroid Transforaminal Injection L5/S1, and S1

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

Board Certified Anesthesiologist

Board Certified 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 medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Cover sheet and working documents

Utilization review determination dated 05/25/12, 06/07/12

Follow up note dated 04/27/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. Follow up note dated 04/27/12 indicates that the patient presents with back and leg pain bilaterally with burning and tingling paresthesias. The patient reports that her pain improved by 90% with last LESI. The patient notes that her left sided radicular pain is resolved, residual component is right sided burning paresthesias and right S1 numbing paresthesias. The patient admits to past surgical history of back surgery in 2011, 2010. On physical examination lumbar range of motion shows decreased flexion with pain. Palpation of the left lower back and right lower back demonstrates mild tenderness and muscle spasms. Motor strength is rated as 5/5 in the bilateral lower extremities. Straight leg raising is positive on the right side with pain radiating to the right buttocks and posterior thigh. Bilateral patellar reflex is 1/4. Bilateral Achilles reflex is 0/4. MRI of the lumbar spine dated 07/07/10 reportedly shows vertical rods and pedicular screws involving the vertebral bodies of L5 and S1. At L4-5 there is moderate diffuse disc bulge with mild left paracentral disc herniation with mild encroachment on the left L5 nerve root with moderate narrowing of the lower aspect of the neural foramina on the left. EMG/NCV reportedly shows chronic bilateral L5 radiculopathy.

Initial request for right lumbar epidural steroid injection L5-S1 was non-certified on 05/25/12 noting that considering that claimant has residual right-sided symptoms associated with sensory and deep tendon reflex deficits, transforaminal epidural steroid injection is justified as reasonable and medically appropriate; however, the request is for right L5-S1 and S1. The left side was performed at the L4-5 and L5-S1 levels and there is no indication as to the rationale for performing the right side at the lower level. The denial was upheld on appeal dated 06/07/12 noting that the EMG/NCV shows bilateral L5 radiculopathy. Doing the injection at L5-S1 will only get the S1 nerve root.

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

Based on the clinical information provided, the request for right lumbar epidural steroid transforaminal injection L5-S1 and S1 is not recommended as medically necessary, and the two previous denials are upheld. The patient underwent previous lumbar epidural steroid injection on the left at L4-5 and L5-S1 on 03/14/12 and reported 90% pain relief with residual right sided burning paresthesias. It appears that the patient is an appropriate candidate for a right sided lumbar epidural steroid injection; however, as noted by the previous reviewers, L5-S1 is not the appropriate level. EMG/NCV shows chronic bilateral L5 radiculopathy. Performing the transforaminal epidural steroid injection at L5-S1 will only address the S1 nerve root. The previous left sided injection was performed at L4-5 and L5-S1, and it is unclear why the lower level is being requested on the right side. 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:

ACOEM-AMERICA 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)