

SENT VIA EMAIL OR FAX ON  
Feb/28/2012

## Pure Resolutions LLC

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**  
Feb/24/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Lumbar ESI #3 L5/S1

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

**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  
Cover sheet and working documents  
Utilization review determination dated 02/06/12, 01/11/12  
Handwritten note dated 10/24/08, 01/27/11, 02/24/11, 04/25/11, 05/23/11, 06/20/11, 07/18/11, 08/15/11, 05/18/10, 06/03/10, 07/27/10, 08/24/10, 09/12/11, 10/10/11, 11/07/11, 12/09/11, 12/16/11, 01/05/12, 02/03/12  
Initial evaluation dated 01/13/12  
Daily note dated 01/17/10

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. The earliest record submitted for review is a handwritten note dated 10/24/08. Initial evaluation dated 01/13/12 indicates that the patient presents to PT with primary complaint of headaches and chronic neck pain. Treatment to date is noted to include cervical surgery, 2 lumbar surgeries, multiple knee

operations and right shoulder surgery. Tenderness patient reports that PT has made pain worse in the past. Physical examination addresses only the cervical spine and upper extremities. Note dated 02/03/12 indicates that facet loading is positive bilaterally. There is tenderness to palpation to the bilateral lumbar paravertebral areas. Straight leg raising is positive on the left, negative on the right.

Initial request for lumbar epidural steroid injection #3 L5-S1 was non-certified on 01/11/12 noting that a more comprehensive physical examination of the lumbar spine was not provided in the most recent medical report submitted. The patient was noted to have undergone previous lumbar epidural steroid injections which resulted in 90% pain relief for over a month. However, there was no objectively documented decreased need for pain medications and improved function in terms of activities of daily living associated with the previous injections. The levels to be injected were not specified. The denial was upheld on appeal dated 02/06/12 noting that no additional information was provided to address the issues raised in the initial review. The levels to be injected were not specified. The latest documents submitted for review are PT progress notes with respect to the cervical spine.

**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 lumbar epidural steroid injection #3 L5-S1 is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to the lumbar spine to date or the patient's response thereto submitted for review. There are no imaging studies/electrodiagnostic results provided to support a diagnosis of active lumbar radiculopathy. There is no current, detailed physical examination submitted for review to establish the presence of active lumbar radiculopathy. The dates of the previous two injections are not documented, and the patient's objective, functional response to these procedures is not provided. The Official Disability Guidelines support repeat epidural steroid injection with evidence of at least 50-70% pain relief for at least 6-8 weeks.

**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)