

# Pure Resolutions LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Oct/30/2012

**IRO CASE #:**

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

RT TF ESI @ L2/3, L3/4, L4/5, Fluoroscopy with sedation

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

Anesthesiology/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)

**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  
Progress notes dated 05/06/08-  
Operative report dated 05/07/08  
Lab reports 05/08/08  
Progress notes dated 01/30/12  
Peer review report dated 03/14/12  
Designated doctor's evaluation dated 05/07/12  
MRI lumbar spine dated 05/24/12  
CT abdomen and pelvis dated 06/08/12  
Initial behavioral medicine evaluation dated 06/27/12  
Advanced pain care medical records dated 06/27/12-10/10/12  
Daily note / billing sheet dated 06/29/12  
Preauthorization requests  
Utilization review determination dated 07/20/12  
Peer review report dated 07/26/12  
History and physical examination dated 08/17/12  
Utilization review determination dated 09/04/12  
Post designated doctor's required medical evaluation dated 10/01/12  
Carrier submission report dated 10/23/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male whose date of injury is xx/xx/xx. The patient is status post previous right inguinal herniorrhaphy performed on 05/07/08. Note dated 12/09/11 indicates that the patient was moving furniture on the date of injury and felt pain above his scar. On exam no hernia was noted. Peer review dated 03/14/12 indicates there is no evidence of a work-related injury which can be supported by the records. An examination performed in December showed that his back was "normal". He requires no further forms of intervention with respect to described events of 12/07/11 as no injury can be demonstrated based upon available records. Designated doctor evaluation dated 05/07/12 indicates that the patient has not reached MMI and should undergo the requested MRI. MRI of the lumbar spine dated 05/24/12 revealed trace annular bulging and desiccation with small osteophytes anteriorly at L2-3. The central canal, foramina and facets are preserved. At L3-4 it is noted that L3 is slightly anteriorly subluxed with respect to L4 by approximately 2 mm; broad based disc bulging lateralizes to the left foramen. In combination with facet degeneration, there is minimal narrowing of the left foramen close to the exiting nerve root. This foramen may be further narrowed by a small synovial cyst from the left facet joint. The central canal and right foramen are only slightly distorted. At L4-5 similar changes are present. The central canal and right foramen are generally preserved. Peer review dated 07/26/12 indicates that the lumbar MRI findings are incidental findings. Claimant has multilevel degenerative changes of the lumbar spine. At most, the claimant sustained a lumbar strain without radiculopathy.

Request for right transforaminal epidural steroid injection L2-3, L3-4, L4-5 fluoroscopy with sedation was non-certified on 09/04/12 noting that guidelines indicate radiculopathy must be documented and objective findings on physical examination need to be present and must be corroborated by imaging studies and/or electrodiagnostic testing. The patient has no objective evidence of radiculopathy on physical examination and no MRI report included in the medical records documenting any nerve root compression. There is no documentation of lower levels of conservative care of physical therapy, home exercise program being exhausted. The guidelines only support two nerve root levels to be injected and the requesting physician is requesting three nerve root levels. Physical examination on 09/12/12 notes lumbar range of motion is decreased. Patient with pain on facet loading of the affected side. Trigger points are noted of the lumbar paraspinal. Straight leg raising is negative.

**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 TF epidural steroid injection at L2-3, L3-4, L4-5, fluoroscopy with sedation is not recommended as medically necessary. The submitted physical examination fails to establish the presence of active lumbar radiculopathy. The Official Disability Guidelines note that no more than two nerve root levels should be injected using transforaminal blocks, and the current request is excessive. An examination performed in December showed that his back was "normal". He requires no further forms of intervention with respect to described events of 12/07/11 as no injury can be demonstrated based upon available records. Peer review dated 07/26/12 indicates that the lumbar MRI findings are incidental findings. Claimant has multilevel degenerative changes of the lumbar spine. At most, the claimant sustained a lumbar strain without radiculopathy. Given the current clinical data, the requested injections are not considered 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)