

# Pure Resolutions LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Oct/15/2013

**IRO CASE #:**

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

Left L5-S2 transforaminal ESI

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

Board Certified PM&R  
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  
Chiropractic therapy reports 05/21/13-08/13/13  
MRI lumbar spine 05/13/13  
Electrodiagnostic studies 05/29/13  
Procedure report 07/31/13  
Clinical record 08/22/13  
Prior utilization reviews 09/03/13 and 09/18/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who sustained an injury on xx/xx/xx when he was involved in a motor vehicle accident. The patient was followed for complaints of low back pain radiating to the lower extremities. MRI of the lumbar spine on 05/13/13 showed a disc protrusion/disc herniation at L4-5 and L5-S1 mildly indenting the thecal sac. Electrodiagnostic studies on 05/29/13 demonstrated evidence of a left S1 radiculopathy. The patient had one epidural steroid injection at L5-S1 to the left side on 07/31/13. Follow up on 08/22/13 stated that the patient had benefits from the prior injection for approximately three days. The patient was attending chiropractic and physical therapy which was reported to be going well. Physical examination demonstrated positive straight leg raise findings to the left side with no motor weakness in the lower extremities. There was subjective decreased sensation in the surface of the left foot and posterior calf. Reflexes were symmetric. The patient was recommended

for L5-S1 and S1-2 epidural steroid injections at this visit. The requested epidural steroid injections at L5-S1 and S1-2 were denied by utilization review on 09/03/13 as prior epidural steroid injections provided only three days of relief and guidelines recommended at least six to eight weeks of relief with 50% or greater pain reduction to support repeat epidural steroid injections. The request was again denied by utilization review on 09/18/13 due to the lack of efficacy for the primary blocks.

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

The patient has objective evidence supporting a left S1 radiculopathy. The patient had prior epidural steroid injections at L5-S1 disc interspace that provided approximately three days of benefit. Current evidence based guidelines recommend that patients have at least six to eight weeks of pain relief with objective findings for functional improvement to support repeat epidural steroid injections. Given the limited relief documented with the initial epidural steroid injection it is highly unlikely that the patient will have any further benefit from repeat epidural steroid injections. Therefore it is the opinion of this reviewer that medical necessity is not established at this time as the request is not supported by the clinical documentation and does not meet current evidence based guidelines regarding repeat epidural steroid injections. As such the prior denial is upheld.

**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)