

Pure Resolutions LLC

An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 405-0870
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

May/31/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar ESI

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

Anesthesiologist and 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes dated 03/28/12 – 04/08/13
X-rays of the cervical, thoracic, and lumbosacral spine dated 10/26/11
MRI of the lumbar spine dated 03/22/12
Electrodiagnostic studies dated 03/28/12
Therapy note dated 03/14/13
Previous utilization reviews dated 04/12/13 & 04/23/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his low back. The x-rays of the lumbosacral spine dated 10/26/11 revealed a grade 1 spondylolisthesis of L4 on L5. The MRI of the lumbar spine dated 03/22/12 revealed a 3-4mm broad based disc bulge at L4-5 extending into the neuroforamen of the right bilaterally. Mild foraminal stenosis was noted. The electrodiagnostic studies dated 03/28/12 revealed a chronic left sided L4-5 radiculopathy. The clinical note dated 03/28/12 details the patient complaining of low back pain with radiation of pain to both lower extremities. The patient also noted a tingling sensation in the left lower extremity. The note does detail the patient utilizing Naproxen, Hydrocodone, and Flexeril for ongoing pain relief. The clinical note dated 10/11/12 details the patient stating the initial injury occurred when he fell approximately 6 feet off a pallet in September of 2011. The clinical note dated 02/07/13 details the patient having previously undergone an epidural steroid injection of the lumbar region which did provide the patient with 25% pain reduction for approximately 10 days. The therapy note dated 03/14/13 details the patient having completed 8 physical therapy sessions to date. The clinical note dated 04/08/13 details the patient continuing with low back pain.

The previous utilization review dated 04/12/13 for a lumbar epidural steroid injection resulted in a denial secondary to a lack of objective evidence indicating a lumbar radiculopathy by clinical exam. Additionally, no information had been submitted regarding the specific level of the intended injection.

The utilization review dated 04/23/13 for a lumbar epidural steroid injection resulted in a denial secondary to the patient's inadequate response regarding the previous epidural steroid injection.

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

The documentation submitted for review elaborates the patient complaining of low back pain with radiation of pain into the lower extremities. An epidural steroid injection would be indicated in the lumbar region provided the patient meets specific criteria to include a positive response regarding the previous epidural injection. The documentation does detail the patient having previously undergone an epidural steroid injection in the lumbar region which resulted in a 25% reduction in pain for 10 days. Guidelines recommend a subsequent epidural injection provided the patient experienced a 50-70% reduction in pain for 6-8 weeks. Given the inadequate response regarding the patient's previous epidural injection in the lumbar region, this request is not indicated as medically necessary. As such, it is the opinion of the reviewer that the request for an epidural steroid injection in the lumbar region is not recommended 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)