

# Pure Resolutions LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Jul/15/2014

**IRO CASE #:**

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

Left L5 Right S1 Transforaminal Injection

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

Board Certified PM&R

**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

Utilization reviews dated 05/29/14, 05/20/14

Office visit dated 05/09/14

Follow up evaluation dated 05/07/14, 04/28/14, 04/14/14

Physical therapy daily note dated 04/29/14, 04/17/14, 04/11/14, 04/10/14, 04/09/14

Physical therapy evaluation dated 04/09/14

Initial evaluation dated 04/07/14

Home exercise sheet

Physical therapy re-evaluation dated 04/29/14

CT lumbar spine dated 04/19/14

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female whose date of injury is xx/xx/xx. The mechanism of injury is described as injured the low back and left leg. CT of the lumbar spine dated 04/19/14 revealed at L5-S1 there is a right sided spondylolysis of L5. There is a broad based disc protrusion, degenerative facet changes, no central canal stenosis and no neural foraminal stenosis. The patient completed approximately 5 visits of physical therapy. Office visit note dated 05/09/14 indicates that she is working with restrictions. Medications are listed as Gabapentin, ibuprofen, cyclobenzaprine and Tramadol. On physical examination paravertebral muscles are tender bilaterally. Lumbar range of motion is painful and restricted. Straight leg raising on the right causes some radiation of pain down the right leg and on the left causes some radiation down the left leg. Strength is rated as 4 in the lower extremities. Light touch sensation is intact.

Initial request for left L5 right S1 transforaminal injection was non-certified on 05/20/14 noting

that the left L5 transforaminal injection would be supported, but the right S1 transforaminal injection is not supported by the imaging studies. The denial was upheld on appeal dated 05/29/14 noting that there was no additional information provided that would support a right S1 transforaminal epidural steroid injection; therefore, medical necessity of the appeal request for left L5-right S1 transforaminal injections has not been established.

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

The patient sustained injuries on xx/xx/xx. The submitted records fail to establish that the patient has been initially unresponsive to conservative treatment as required by the Official Disability Guidelines, noting that the patient has completed only 5 sessions of physical therapy. The patient's physical examination fails to establish the presence of active lumbar radiculopathy, and the submitted lumbar CT scan fails to document any significant neurocompressive pathology at L5-S1. No additional information has been submitted for review to address the issues raised by the initial reviewers. As such, it is the opinion of the reviewer that the request for left L5 right S1 transforaminal injection 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)