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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Mar/13/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OP Bilateral Transforaminal ESI L4/5 L5/S1

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

Board Certified Anesthesiologist

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. The patient reported low back pain secondary to lifting. MRI of the lumbar spine dated 06/14/12 revealed at L4-5 the disc is intact without narrowing, desiccation, annular tear or disc protrusion. There is moderate constriction of the thecal sac due to abundant epidural fat. There is not bony central canal or foraminal stenosis. Minor degenerative facet changes are present. The appearance is unchanged from prior study dated 12/27/10. At L5-S1 there is evidence of prior surgery with bilateral laminotomy defect, anterior interbody fusion and posterior wire cable fixation. Interbody bone graft material is fully incorporated and solidly fused. The central canal and neural foramina are well decompressed. There is no evidence of substantial epidural or perineural fibrosis. New patient evaluation dated 01/04/13 indicates that treatment to date includes bilateral hemilaminectomy and foraminotomy L4-5 and L5-S1 with discectomy and PLIF at L4-5 and L5-S1, physical therapy, multiple lumbar epidural steroid injections, TENS unit and medication management. The patient subsequently underwent bilateral L4-5, L5-S1 transforaminal epidural steroid injection on 07/08/13. Follow up note dated 08/05/13 indicates the LESI reduced pain by 50% but had increased pain initially. There are no changes on radicular pain. The patient underwent bilateral L4-5, L5-S1 transforaminal epidural steroid injection on 09/26/13 which provided 80% pain relief for 2 weeks. Note dated 12/19/13 indicates the last epidural steroid injection offered 80% reduction of pain. The patient is not taking any medications. On physical examination gait is antalgic. Deep tendon reflexes are normal. Strength is rated as 5/5 throughout.

Initial request for OP bilateral transforaminal epidural steroid injection L4-5 L5-S1 was non-certified on 01/13/14 noting that the most recent physical examination did not reveal

significant neurologic deficits in the lumbar spine to establish the presence of L4-5 and L5-S1 radiculopathy. In addition, failure of adequate conservative care rendered subsequent to the ESIs performed on 09/26/13 was not demonstrated. The denial was upheld on appeal dated 02/06/14 noting that there is no additional information provided to address the issues raised by the initial denial. Note dated 01/22/14 indicates that deep tendon reflexes are normal and strength is 5/5 in the lower extremities.

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

The patient sustained a lifting injury on xx/xx/xx. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to establish the presence of active lumbar radiculopathy with 5/5 strength and normal deep tendon reflexes. As such, it is the opinion of the reviewer that the request for OP bilateral transforaminal epidural steroid injection L4-5 L5-S1 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
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)