

# **Pure Resolutions LLC**

**An Independent Review Organization**

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## **Review Outcome:**

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

Physical Medicine And Rehab

## **Description of the service or services in dispute:**

Outpatient left L4-S1 Transforaminal Epidural Steroid Injection Under Anesthesia X 3

**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)

## **Patient Clinical History (Summary)**

The patient is a male who sustained an injury on xx/xx/xx. The patient developed complaints of low back pain radiating to the lower extremities. The patient was followed for post-laminectomy syndrome and chronic lower extremities complaints. Electrodiagnostic studies from 02/06 noted evidence of radiculopathy at L3-4 and L4-5. The last MRI available for review was from 02/13/08 noting post-operative changes at L4-5 and L5-S1 consistent with a prior lumbar fusion. There was a mild anterolateral epidural scar at L5-S1 adjacent to left S1 nerve root. The patient was followed for continuing low back and lower extremities symptoms. The 12/22/14 clinical record had no focal neurological deficits. There was tenderness to palpation of the lumbar spine with straight leg raise positive to the left. There was loss of lumbar spine range of motion. The 01/07/15 clinical record noted persistent low back pain with numbness in the left foot and leg. Physical examination did not identify any focal neurological findings. The requested left L4 through S1 epidural steroid injections with anesthesia times three were denied on 01/12/15 and 01/22/15 as there was limited clinical documentation of conservative treatment and it was unclear what the response was to prior epidural steroid injections. Guidelines did not support a series of three epidural steroid injections and there was lack of clinical documentation of any needle anxiety procedure anxiety or needle phobia to support the anesthesia portion of the request.

**Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.**

The patient has been followed for a long history of chronic low back and lower extremities symptoms stemming from prior two level lumbar fusion at L4-5 and L5-S1. No updated imaging studies were available for review for the lumbar spine noting continuing nerve root involvement at either L4-5 or L5-S1. Although the patient continues to describe lower extremities symptoms the physical examination findings were unremarkable for any focal neurological deficits consistent with active lumbar radiculopathy. The clinical documentation submitted for review did not identify any procedural anxiety or needle phobia to support anesthesia services. Guidelines also do not recommend a series of three epidural steroid injections and there is limited clinical documentation regarding efficacy for prior epidural steroid injections for this patient. Therefore it is the opinion of this reviewer that medical necessity for the requested services is not based on guideline recommendations and the prior denials are upheld.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)