



Notice of Independent Review Decision

DATE OF REVIEW: 12/13/07

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical appropriateness of caudal lysis of adhesions, L2-L5 (5-day infusion).

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

Texas Licensed Pain Management Specialist

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)

The previously denied request for caudal lysis of adhesions, L2-L5 (5-day infusion).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Fax Cover Sheet/Notes/Comments/Appeal Request dated 12/4/07, 12/3/07, 11/30/07, 11/26/07, 10/26/07, (unspecified date).
- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 12/3/07.
- Notice to Inc. of Case Assignment dated 12/3/07.
- Documentation Request Letter dated 11/26/07.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 11/21/07.

- **Request for a Review by an Independent Review Organization dated 11/15/07.**
- **Pre-Authorization Determination Notification dated 11/5/07, 10/8/07.**
- **Peer Review Report (unspecified date).**
- **Texas Worker's Compensation Pre-Authorization Request dated 9/12/07.**
- **Medical Necessity Letter dated 9/13/07.**
- **Clinic Discharge Instruction Sheet dated 9/6/07.**
- **Clinic Progress Note dated 9/6/07.**
- **Lumbar Spine MRI dated 10/9/07.**

PATIENT CLINICAL HISTORY [SUMMARY]:

Age: xx years

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Not provided for this review.

Diagnosis:

1. Chronic low back pain.
2. Lumbar spondylosis.
3. Lumbar radiculopathy.

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

The patient is a xx-year-old male who was sustained a work-related injury on xx/xx/xx due to limited documentation. Mechanism of the injury not submitted. Diagnoses are

1. Chronic low back pain.
2. Lumbar spondylosis.
3. Lumbar radiculopathy.

From the limited information provided for review, it appears that this claimant had a history of chronic low back pain, secondary to lumbar spondylosis, as well as lumbar radiculopathy. Previously performed conservative treatment was not submitted for review. A review of the lumbar MRI performed on October 9, 2007, revealed degenerative disk changes with an annular tear 2 mm, with subligamentous central disk protrusion at L4-L5 level; and moderate to severe left foraminal stenosis. Of note, there was no documentation submitted with clinical examination and medication profile. The requesting provider has established medically necessity for the procedure stating that the lysis of adhesion will be necessary to free any nerve entrapment that the claimant may have sustained through the years. In addition, there was a recommendation to perform bilateral lumbar medial branch blocks following the requested procedure of lysis of adhesions. Currently, the patient rates his back at 8/10 in severity and described it as burning and stabbing.

After review of the information submitted, it is the opinion of this reviewer to uphold the denial to proceed with the requested intervention of caudal lysis of adhesions. The submitted radiographic imaging studies report did not describe the presence of any compressive lesion upon any neural elements in the lumbar spine. Furthermore, there were no epidural adhesions described in this submitted report as well. From the subjective and objective findings, the clinical indication of the request could not be established. The purpose of percutaneous epidural adhesiolysis is to minimize the adverse effects of the epidural scarring which can produce nerve entrapment, pain, and physically prevent direct application of analgesics or anti-inflammatory agents to the

involved nerve structures. This procedure is strongly supported in patients who are suffering from post lumbar surgery syndrome.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN 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.
Low Back-Epidural Injections
- 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 MEDICAL LITERATURE (PROVIDE A DESCRIPTION).

X OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).

1. Boswell MV, Trescot AM, Datta S et. al. Interventional Techniques: Evidence-Based practice guidelines in the management of chronic spinal pain.
2. Pain Physician 2007; 10:7 through 111.
3. Trescot AM, Chopra T., Abdi S. et al. Systematic Review of Effectiveness and Complications of Adhesiolysis in the Management of Chronic Spinal Pain: an update.

4. Pain Physician 2007; 10:129 through 46.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.