

C-IRO, Inc.
An Independent Review Organization
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Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 25, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar ESI L2-4/Lysis of Adhesions, 62264, 62310, 77003, 72275

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

MD, Board Certified Orthopedic Surgeon

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for Lumbar ESI L2-4/Lysis of Adhesions, 62264, 62310, 77003, 72275.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/1/08, 8/18/08
ODG Guidelines and Treatment Guidelines
Orthopedics, 7/17/08, 5/22/08
MRI of Lumbar Spine, 3/21/06
Lumbar Myelogram, 7/11/08
Post Myelogram CT Scan of Lumbar Spine, 7/11/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a male who was injured while at work on xx/xx/xx. He was treated initially by a chiropractor and underwent surgery in the form of a lumbar laminectomy at L5/S1 on 12/07/06. It is stated that he has some chronic radicular problems. He had an MRI scan prior to the initial surgery, which revealed a central herniation at L5/S1. This study was performed on 06/21/06 at MRI scan. It is stated that there was some reduction in signal intensity at the L5/S1 level with a central herniation with a midline annular tear but no evidence on the study of neural foraminal compression, although he did have some radiculopathy on EMG/NCV study.

He subsequently came under the care of the requesting physician who ordered a MRI arthrogram with post myelographic CT scan. This was performed and read and seemed to show a small extradural indentation at L5/S1 but no significant canal stenosis, and no mention is made of any problem with the L5/S1 level on the myelogram or plain films. There was no evidence of any adhesions on these plain films. He also underwent a post myelographic CT scan, and it was stated at L5/S1 that there were no significant abnormalities seen. At L4/L5 a 2-mm extradural indentation was seen. There was no foraminal stenosis and no evidence of any adhesions noted on this study. The treating physician based the recommendation on the ongoing right-side complaints and some decreased sensation of the right S1 dermatome and a weakened eversion of the foot, i.e. not S1 (and his reflexes being 1+ in the Achilles on the right and 2+ on the left). Based upon persistent radiculopathy, the physician recommended a repeat lumbar epidural steroid injection with neural lysis. A psychological screen has been performed.

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

In order for a patient to meet guidelines for a neural lysis of adhesions, there need to be adhesions present. In this particular case, all the studies provided have not revealed any evidence of adhesions, and hence the request for neural lysis of such adhesions has not been substantiated within the medical records. In addition, the medical records indicate that the patient's ongoing problems are not only chronic but also seem to lack specificity as he complains of L5 root-related symptoms as well as S1 symptoms. These problems are not compatible with the imaging studies provided. For each of these reasons, the reviewer finds that medical necessity does not exist for Lumbar ESI L2-4/Lysis of Adhesions, 62264, 62310, 77003, 72275.

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
- AHCPH- 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)**