



Notice of Independent Review Decision

**DATE OF REVIEW:** 3/29/10

**IRO CASE #:**                      **NAME:**

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

Determine the appropriateness of the previously denied request for outpatient left lumbar epidural steroid injection (ESI) with catheter at L5-S1 (CPT codes 62282, 62319, 62284 and 72275).

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

Texas licensed 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)

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 previously denied request for outpatient left lumbar epidural steroid injection (ESI) with catheter at L5-S1 (CPT codes 62282, 62319, 62284 and 72275).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Doctors Report dated 2/17/10, 2/2/10.
- Progress Note dated 1/28/10.
- Operative Note dated 1/5/10.
- Initial Evaluation dated 12/14/09.
- Physician Report dated 11/16/09, 11/2/09, 10/12/09, 9/21/09.
- Final Report dated 11/13/09.

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:** xx

**Gender:**

**Date of Injury:** xx/xx/xx

**Mechanism of Injury:** Hit in the back by a resident of “The Children’s Home.”

**Diagnosis:** Low back pain with radiculopathy.

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

This female injured her low back on xx/xx/xx. The mechanism of injury occurred when she was hit in the back by a resident of xxxx The diagnosis was low back pain with radiculopathy. An MRI was performed on 11-13-09. It was notable for diffuse annular bulging at L4-5 and L5-S1. There was noted right foraminal stenosis at L5-S1. There is mild bilateral foraminal stenosis. There was an initial lumbar ESI, performed by Dr. on 01-05-10, which was catheter directed with a neurolytic. It was noted on a follow up, on 01-28-10, that the patient had received a reduction in pain from a 9/10 to a 2-3/10, from the first ESI. She was still noted to have radiculopathy on exam. There was a request for a repeat ESI with lysis of adhesions. It was denied based on the fact that there had not been a 6-8 week duration before the request for the 2<sup>nd</sup> ESI. The lysis of adhesions was denied based on the lack of documentation for the presence of epidural adhesions. The ODG states, “Adhesiolysis, percutaneous – Not recommended due to the lack of sufficient literature evidence (risk vs. benefit, conflicting literature).” Therefore, 62282 is not necessary. Similarly, 62284 injection of myelographic dye and 72275 epidurography are also not necessary. In this case, the ODG will support up to 2 initial ESIs in the diagnostic phase. In the therapeutic phase, there is support for repeat ESIs if there is a reduction in pain by 50-70% for a duration of 6-8 weeks. In this case, this is not considered a therapeutic ESI. Only one initial ESI was performed. The ODG will allow up to 2 total ESIs in this diagnostic phase. However, the ODG does not support the use of adhesiolysis for the treatment of radiculopathy. Furthermore, there was no documentation provided that there was the presence of epidural fibrosis. Based on this, only the left lumbar ESI is considered medically necessary (62319).

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
- x ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Official Disability Guidelines (ODG), Treatment Index, 8<sup>th</sup> Edition (web), 2010, Low Back – ESI. *“When used for diagnostic purposes the following indications have been recommended: To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies; 3) To help to determine pain generators when there is evidence of multi-level nerve root compression; 4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive.”*; Low Back - adhesiolysis, percutaneous.

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