

Notice of Independent Review Decision

DATE OF REVIEW: 10/06/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient lumbar epidural steroid injection and percutaneous lysis of lumbar epidural adhesions

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Partially Overturned

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Outpatient lumbar epidural steroid injection and percutaneous lysis of lumbar epidural adhesions Partial approval: Outpatient lumbar epidural steroid injection <u>is</u> warranted. Percutaneous lysis of lumbar epidural adhesions is <u>not</u> warranted.	62311, 62264	-	Partially Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request	Dr.	21	09/14/2010	10/06/2010
2	Referral		1	09/17/2010	09/17/2010
3	Medical Literature		12	09/17/2010	09/17/2010
4	Diagnostic Test	Diagnostics LLC	3	07/08/2010	07/08/2010
5	Diagnostic Test	Imaging Center	4	06/08/2010	06/08/2010
6	Diagnostic Test	Integrative Health and Medical	4	07/13/2010	07/13/2010
7	IRO Request	TDI-DWC	5	09/13/2010	09/16/2010
8	Office Visit Report	Orthopedics	5	07/08/2010	08/25/2010
9	Initial Denial Letter		9	08/31/2010	09/09/2010
10	Office Visit Report	PA	36	06/09/2010	07/14/2010

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a female employee who suffered a fall on xx/xx/xx. She suffered a direct blow injury to the right shoulder and a straining twisting injury to the lumbar spine. The injured employee has a past history of lumbar spine injury 4 years prior to this injury. She was treated with a physical therapy regimen and significantly improved. Most recently, she has severe low back pain and lower extremity pain. An EMG/NCV was performed on 08/13/10 which revealed S1 radiculopathy changes bilaterally, worse on the right compared to the left. She has diminished reflex changes at the patellar tendon and achilles tendon. An MRI scan of the lumbar spine obtained on 06/08/2010 revealed disc pathology at L4-L5 and L5-S1 with disc protrusions and compression of the bilateral S1 nerve roots. The patient was treated conservatively with physical therapy, anti inflammatories and activity restriction. A request for outpatient lumbar epidural steroid injection and percutaneous lysis of epidural adhesions was considered on prior review and was non-certified on both initial and appeal level reviews. This is an IRO request for an outpatient lumbar epidural steroid injection and percutaneous lysis of epidural adhesions

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

Is the performance of lumbar epidural steroid injection and percutaneous lysis of epidural adhesions medically necessary and appropriate at this time? The available medical data, which shows a neurocompressive lesion on the lumbar spine MRI, along with neurological findings supportive of lumbar radiculopathy, supports the medical necessity of the outpatient lumbar epidural steroid injection. This assessment is also supported by the ODG Guidelines, cited below. Therefore, the prior denial of this outpatient lumbar epidural steroid injection was not appropriate and is medically necessary and should be overturned.

The request for the percutaneous lysis of adhesions is not, however, medically appropriate. The available clinical data does not support the presence of any epidural adhesions. And, as noted in ODG Guidelines below, Lumbar Chapter, the procedure of Percutaneous lysis of adhesions is not recommended. Therefore, the prior denials of the procedure were medically appropriate and the denial should be upheld

Epidural steroid injections (ESIs), therapeutic: **Criteria for the use of Epidural steroid injections:**

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy must be documented. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#))

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.

(4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the “diagnostic phase” as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.

(5) No more than two nerve root levels should be injected using transforaminal blocks.

(6) No more than one interlaminar level should be injected at one session.

(7) *Therapeutic phase:* If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be required. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute

exacerbation of pain, or new onset of symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. ([CMS, 2004](#)) ([Boswell, 2007](#))

(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

(9) Current research does not support a routine use of a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.

(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.

(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

Adhesiolysis, percutaneous:

Preliminary suggested criteria for percutaneous adhesiolysis while under study:

- The 1-day protocol is preferred over the 3-day protocol.
- All [conservative](#) treatment modalities have failed, including epidural steroid injections.
- The physician intends to conduct the adhesiolysis in order to administer drugs closer to a nerve.
- The physician documents strong suspicion of adhesions blocking access to the nerve.
- Adhesions blocking access to the nerve have been identified by Gallium MRI or Fluoroscopy during epidural steroid injections.

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
- 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)