

SENT VIA EMAIL OR FAX ON
Feb/22/2011

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/18/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

LESI L4/5 with Fluoro; lysis of adhesions

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx-year-old female who sustained a work related injury to her lower lumbar area. Neither the mechanism of injury nor the initial diagnosis was provided. The claimant underwent a lumbar laminectomy and microdiscectomy at L4-5 in 02/10. Postoperatively the claimant continued to have pain despite postoperative physical therapy and medication. The claimant completed a chronic pain program. When the claimant saw Dr. on 01/07/11 she had recently noticed an increase in her low back pain that radiated down her left leg. She rated her pain as 8/10 and also complained of numbness and tingling in her left leg. On examination the claimant had tenderness to her mid to lower lumbar region, decreased flexion and extension and a mildly positive straight leg raise on the left. Her motor strength remained intact although she had a mild paresthesias along the lateral aspect of her left lower extremity. Dr. diagnosed a left L5 radiculitis and recommended an epidural steroid injection with lysis of adhesions. This was noncertified by 2 peer reviews. The first peer review noncertified the epidural steroid injection because the clinical records provided did not state that there was a failure of conservative measures such as previous physical therapy and oral medications. Also clinical records did not state if the claimant's diabetes was contributing to her symptoms. The second peer review also noncertified the epidural steroid injection and lysis of adhesions. The report stated that the claimant had had an epidural steroid injection with 50 percent improvement but there was no documentation of pain relief

for at least 6-8 weeks such as the decreased need for pain medications and functional response. Also evidence-based guidelines did not support the lysis of adhesions.

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

This case has been previously reviewed and deemed not medically necessary. The request is for a lumbar epidural steroid injection and lysis of adhesions.

The guidelines specifically do not recommend percutaneous adhesiolysis due to the fact that there is insufficient literature supporting its efficacy in long-term studies, also referred to as epidural neurolysis. This is not indicated for chronic symptomology.

The claimant has had an epidural steroid injection in the past. The chief reason for denial is that the percutaneous adhesiolysis is not deemed medically necessary, per Official Disability Guidelines.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates. Low Back:

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, reduction of medication use 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](#)) Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
- (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 supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular 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.)

Percutaneous Adhesiolysis

Not recommended due to the lack of sufficient literature evidence (risk vs. benefit, conflicting literature). Also referred to as epidural neurolysis, epidural neuroplasty, or lysis of epidural

adhesions, percutaneous adhesiolysis is a treatment for chronic back pain that involves disruption, reduction, and/or elimination of fibrous tissue from the epidural space. Lysis of adhesions is carried out by catheter manipulation and/or injection of saline (hypertonic saline may provide the best results). Epidural injection of local anesthetic and steroid is also performed. It has been suggested that the purpose of the intervention is to eliminate the effect of scar formation, allowing for direct application of drugs to the involved nerves and tissue, but the exact mechanism of success has not been determined. There is a large amount of variability in the technique used, and the technical ability of the physician appears to play a large role in the success of the procedure. In addition, research into the identification of the patient who is best served by this intervention remains largely uninvestigated. Adverse reactions include dural puncture, spinal cord compression, catheter shearing, infection, excessive spinal cord compression, hematoma, bleeding, and dural puncture. Duration of pain relief appears to range from 3-4 months. Given the limited evidence available for percutaneous epidural adhesiolysis it is recommended that this procedure be regarded as investigational at this time. ([Gerdesmeyer, 2003](#)) ([Heavner, 1999](#)) ([Belozer, 2004](#)) ([BlueCross BlueShield, 2004](#)) ([Belozer, 2004](#)) ([Boswell, 2005](#)) ([Boswell, 2007](#)) ([The Regence Group, 2005](#)) ([Chopra, 2005](#)) ([Manchikanti1, 2004](#)) ([Epter, 2009](#)) This recent RCT found that after 3 months, the visual analog scale (VAS) score for back and leg pain was significantly reduced in the epidural neuroplasty group, compared to conservative treatment with physical therapy, and the VAS for back and leg pain as well as the Oswestry disability score were significantly reduced 12 months after the procedure in contrast to the group that received conservative treatment. ([Veihelmann, 2006](#))

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES