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Notice of Independent Review Decision

DATE OF REVIEW: 05/03/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Lumbar ESI #2 L4/5 L5/S1 62311. 77003. 72275. 62264-lysis of adhesions

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

Texas Board Certified Orthopedic Surgeon
Texas Board Certified Orthopedic Sports Medicine

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury on xx/xx/xx when he slipped and grabbed a 500 pound pipe to keep from falling. The pipe fell backwards with him, crushing his abdominal area and injuring his low back.

The employee saw Dr. on 04/23/10. Physical examination revealed no tenderness or masses of the abdomen. The bowel sounds were normal. The abdomen was not distended. There was full strength throughout. Sensation was intact to light touch distally. The employee was assessed with abdominal wall contusion. The employee was released from medical care and advised to follow-up as needed.

An MRI of the lumbar spine performed 05/14/10 demonstrated normal findings at L1-L2, L2-L3, and L3-L4. At L4-L5, there was moderate loss of disc signal and mild loss of disc height with an approximately 2-3 mm central disc protrusion/herniation. The anterior margin of the thecal sac was contacted and partially effaced. The spinal canal remains in excess of a centimeter. There was mild compromise of the left and right lateral recesses, as well as mild to moderate neuroforaminal encroachment, left greater than right. At L5-S1, there was loss of disc signal. The spinal canal and neural foramina were normal in caliber.

The employee saw Dr. on 07/12/10 with continued complaints of pain in the low back, left groin, and abdomen. Physical examination revealed mild to moderate tenderness to palpation of the lumbosacral spine. There was slight tenseness of the paravertebral muscles. Lumbar range of motion was slightly decreased in all directions. The employee was able to heel and toe walk with moderate difficulty. Straight leg raise was reported as positive bilaterally. Examination of the abdomen revealed a well-healed laparotomy scar. There was mild tenderness to palpation of the lower quadrants. There was no organomegaly or rebound tenderness. Bowel sounds were positive. Examination of the left inguinal region revealed mild tenderness to palpation. There was no evidence of inguinal hernia. The employee was assessed with contusion of abdomen/groin, lumbar radiculitis, inguinal strain, and contusion of bilateral upper legs. The employee was recommended for CT of the abdomen and physical therapy.

The employee was seen for Designated Doctor Evaluation on 07/22/10. The employee complained of pain in the abdomen and low back rating 5 to 7 out of 10. The pain worsened with sitting, standing, walking, sleeping, pushing, pulling, stooping, bending, reaching, and sexual activity. Prior treatment included nine sessions of physical therapy, one session of chiropractic therapy, and nine sessions with a TENS unit. Physical examination revealed tenderness to palpation at L4-S1. There was spasm to palpation of the paravertebral muscles at L4-S1. Supine and sitting straight leg raise was to 70 degrees bilaterally. Lumbar range of motion was decreased with full effort with pain. Deep tendon reflexes were normal throughout. The employee was able to heel and toe walk without difficulty. The employee was assessed with lumbar sprain/strain, abdominal pain, bilateral shoulder pain, and leg pain. The employee was not placed at Maximum Medical Improvement (MMI) at that time. The employee was recommended for twelve sessions of physical therapy and a work hardening program.

The employee saw Dr. on 10/19/10 with complaints of low back pain with radiation down the left lower extremity, rating 8 out of 10. The employee also reported occasional numbness and tingling in the feet. Physical examination revealed mild paresthesia on the lateral aspect of the left lower extremity. Motor strength was noted to be weakened

in both lower extremities. Straight leg raise was mildly positive on the left. There was severe tenderness in the lower lumbar region. Lumbar range of motion was decreased due to pain. The employee was unable to walk on his heels or toes due to pain. The employee was assessed with possible herniated nucleus pulposus of the lumbar spine and radiculitis. The employee was continued on oral anti-inflammatories.

The employee saw Dr. on 11/08/10 with complaints of low back pain with radiation down the left lower extremity, rating 8 out of 10. The employee also reported numbness, tingling, and weakness in the entire left leg. Physical examination revealed tenderness to palpation of the lower lumbar region. There was decreased range of motion with pain. Straight leg raise was positive on the left. Motor strength was weakened in both lower extremities. There was continued paresthesia in the lateral aspect of the left lower extremity. The employee was assessed with disc protrusion of L4-L5 and L5-S1 with radiculitis. The employee was recommended for lumbar epidural steroid injection with post injection physical therapy.

The employee saw Dr. on 12/07/10 with continued pain complaints, rating 7 out of 10. Physical examination revealed tenderness in the lumbar spine and the left sacroiliac joint. There was diminished sensation along the left L5 distribution. Motor strength was symmetric. Straight leg raise elicits back and left leg pain. Achilles reflexes were blunted but symmetric. The employee was assessed with protrusion at L4-L5 and L5-S1 and bilateral sacroiliac pain. The employee was recommended for lumbar epidural injection.

The employee saw Dr. on 01/17/11 with complaints of ongoing lumbar, abdomen, and groin pain. The employee also reported left knee pain and tingling in the left posterior thigh. Physical examination revealed tenderness of the lumbar paraspinals bilaterally. Lumbar range of motion was restricted. Straight leg raise provoked low back pain. There was decreased sensation along the left L5 dermatome level. Examination of the abdomen revealed tenderness to palpation. There was tenderness to palpation of the left knee joint. Left knee range of motion was decreased. The employee was assessed with herniated nucleus pulposus, contusion of the abdomen/groin, inguinal strain, and internal derangement of the left knee. The employee was prescribed Ultra, Mobic, and Flexeril.

An MRI of the left knee performed 01/27/11 demonstrated complex abnormal signal in the posterior horn of the medial meniscus extending to the articular surface, consistent with complex Grade 3 tear. The lateral meniscus was intact. There was Grade I chondromalacia patella present with small effusion.

The employee underwent lumbar epidural steroid injection and lumbar lysis of adhesions on 01/31/11.

The employee saw Dr. on 02/10/11. The employee reported 70% relief from the injection. Physical examination revealed tenderness in the mid to lower lumbar region. There was decreased range of motion on flexion and extension. There was diminished sensation along the left L5 distribution. Motor strength was intact. The Achilles reflexes were blunted, but symmetric. The employee was assessed with protrusion at L4-L5 and L5-S1 and bilateral sacroiliac pain. The employee was recommended for post injection physical therapy for the lumbar spine.

The employee saw Dr. on 03/24/11 with complaints of low back pain rating 7 out of 10. The employee reported radiation down the left lower extremity with numbness and tingling. Physical examination revealed tenderness along the mid to lower lumbar

region with decreased range of motion with extension. There were palpable spasms noted. There was diminished sensation along the left L5 distribution. Motor strength was intact, but the employee's gait was noted to be slow and staggered. The patellar reflexes were blunted but symmetric. The Achilles reflexes were 2+ and symmetric. The employee was assessed with protrusion of L4-L5 and L5-S1 with radiculitis and bilateral sacroiliac pain. The employee was recommended for a second epidural steroid injection.

The request for lumbar ESI #2 L4-5 L5-S1 62311 77003 62264 lysis of adhesions was denied by utilization on 04/01/11 as documentation of duration of relief, objective functional improvement, and ability to decreased medication was not provided. Also, there was no documentation of failed conservative management because official and serial physical therapy reports were not submitted for review.

The request for lumbar ESI #2 L4-5 L5-S1 62311 77003 62264 lysis of adhesions was denied by utilization on 04/12/11 due to no documentation of pain relief for at least six to eight weeks, decreased need for pain medications, and functional response after the prior injection. Furthermore, evidence-based guidelines do not consistently and overwhelmingly support lysis of adhesions.

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

The requested lumbar epidural steroid injections at L4-L5 and L5-S1 with lysis of adhesions are not recommended as medically necessary. The clinical documentation does indicate that the employee had 70% relief from the January 2011 epidural steroid injections and lysis of adhesions procedure; however, this measurement was provided almost immediately after the procedure was completed. It is unclear in subsequent clinical evaluations what percentage of pain relief was obtained from the procedures or if the employee demonstrated any significant improvement from the procedure functionally. Current evidence-based guidelines recommend that employee's demonstrate both pain relief and functional improvement from epidural steroid injections for a six to eight week period which is not evident in the clinical notes provided. Additionally, current evidence based guidelines do not support the use of percutaneous adhesiolysis as there is limited evidence in clinical literature that supports the efficacy of the procedure. There is no indication from the clinical notes that the employee had any long term pain relief or functional improvement from the procedure. As such, medical necessity for the procedures is not supported.

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

Official Disability Guidelines, Online Version, Low Back Chapter

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. 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.)
Adhesiolysis, percutaneous
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.