

**ReviewTex. Inc.**  
1818 Mountjoy Drive  
San Antonio, TX 78232 (phone) 210-598-9381 (fax) 210-598-9382  
reviewtex@hotmail.com

Notice of Independent Review Decision

**DATE OF REVIEW:** 02/29/12

**IRO CASE NO.:**

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

Item in dispute: lumbar: lysis of epidural adhesions one day at Pine Creek Medical Center as requested by

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

Board Certified in Anesthesiology and Pain 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**

1. Operative report right greater trochanteric local anesthetic mixture / steroid tendonoosseous and ligamentooosseous injections under fluoroscopy 08/26/10
2. Office notes 01/20/11-12/21/11
3. Peer review 06/06/11
4. CT lumbar spine 09/07/11
5. Epidural steroid injection with catheter / caudal 12/06/11
6. Physical therapy updated plan of care 11/18/11
7. Preauthorization request 12/21/11
8. CT myelogram lumbar spine 10/13/11
9. Preauthorization decision and rationale 11/08/11
10. Preauthorization request 09/27/11
11. Preauthorization decision and rationale 10/03/11
12. Preauthorization decision and rationale 01/04/12
13. Utilization management decision and rationale 01/17/12
14. Prospective review (M2) response TASB Risk Management Fund 02/10/12

**PATIENT CLINICAL HISTORY (SUMMARY):**

The claimant is a female whose date of injury is xx/xx/xx. Records indicate she was status post 360 degree fusion. CT of lumbar spine performed 09/07/11 revealed lumbar fusion L4-S1 with L5 laminectomy. Assessment is limited due to streak artifact from hardware. There appears to be some mild osteopenia from L4-S1 which probably is postoperative. According to the records the claimant complained of chronic intractable low back pain radiating to right leg. She failed to respond to conservative treatment including physical therapy, NSAIDs and low back exercises. CT myelogram of lumbar spine on 10/13/11 revealed postsurgical changes and spinal hardware fixation L4-S1. There is disc disease at L2-3 and L3-4 with moderate to severe disc space narrowing at L3-4 level as described, flattening of anterior thecal sac but no severe spinal stenosis. Narrowing of lateral recess is noted at these levels. There is hypertrophy of posterior osseous structures at L4-5 and L5-S1 with abutting against right posterolateral portion of thecal sac at L4-5 and with effacing right posterolateral thecal sac and encroaching upon right S2 nerve root at L5-S1. A spinal stimulator is present. No acute osseous abnormality was identified.

On 12/06/11 the claimant underwent caudal epidural steroid injection with RACZ catheter. The claimant was recommended to undergo lysis of epidural adhesions. A pre-authorization decision and rationale dated 01/04/12 determined the request for lysis of epidural adhesions one day at as not medically necessary. Official Disability Guidelines does not support lysis of epidural adhesions. There was a lack of significant literature evidence of risk versus benefit. A peer to peer discussion with was completed, but no further clinical information was provided.

A utilization management decision rationale dated 01/17/12 denied reconsideration of lysis of epidural adhesions one day at. It was noted that the claimant already has a spinal cord stimulator in place for prior failed back surgery syndrome. Current imaging studies revealed no evidence of epidural adhesion that otherwise would necessitate lysis of adhesions. Additionally Official Disability Guidelines do not recommend procedure based on lack of definitive evidence of clinical efficacy. Therefore absent imaging of epidural adhesion/fibrosis and lacking Official Disability Guidelines support the request is determined not reasonable and necessary.

Reviewer noted that CT myelogram on 10/13/11 made no mention of flow obstruction or lack of filling of nerve roots. Peer to peer discussion was completed with but no new medical information was provided.

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

Based on the clinical data provided, medical necessity is not established for lumbar lysis of epidural adhesions with one day at Pine Creek Medical Center. The records indicate the claimant had original date of injury on 09/18/00, but sustained a new injury while lifting a box at work on 08/25/11. She had previous lumbar spine surgery and fusion from L4 to S1. Most recent imaging study was CT myelogram performed on 10/13/11 which revealed post-operative changes with pedicle screw fixation and disc expanders appearing to be intact from L4 to S1. There also was noted spinal stimulator present. The myelogram revealed

no evidence of under filling of nerve roots at any level, and there was no evidence of epidural adhesion/fibrosis that would support the need for lysis of adhesions. Moreover, current evidence based guidelines do not support epidural lysis of adhesions noting the lack of sufficient literature evidence to support the efficacy of this procedure.

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

ODG Low Back Chapter--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.