

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Rd Irving, TX 75038
972.906.0603 972.255.9712 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 19, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Lumbar Epidural Steroid Injection at L5-S1 with Fluoroscopy, Epidurography and Lysis of Adhesions

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.10	Lumbar Epidural Steroid Injection at L5-S1 with Fluoroscopy, Epidurography and Lysis of Adhesions		Prosp	1					Upheld

--	--	--	--	--	--	--	--	--	--

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is male who sustained multiple injuries on xx/xx/xx, while working. The claimant was standing under a canopy that fell down and the claimant was struck by a pole and was knocked down. The claimant was diagnosed with a left clavicle fracture, left lateral meniscal tear, cervical and lumbar spine strain, and rib fractures. Conservative treatment with physical therapy was initiated. A brace was provided for questionable fractures of the thoracic spine. A CT scan of the lumbar spine was initially accomplished on August 23, 2012. The CT scan study documented normal alignment of the lumbar spine with no acute radiographic abnormality appreciated. An MRI study of the lumbar spine was later accomplished on August 30, 2012. The MRI study documented decreased disc signal at the L5-S1 level. A diffuse herniated disc that measured 4mm and was noted to reach the thecal sac was noted at the L5-S1 level. There was no mention of any neural compression by the disc protrusion. The claimant was noted to have undergone a previous open reduction internal fixation of the right clavicle fracture on September 26, 2012. A left knee arthroscopy with a partial lateral meniscectomy was accomplished on November 7, 2012. Additional treatment included physical therapy, as well as medications which have included hydrocodone, Tizanidine, and Prilosec. The claimant was most recently evaluated on January 22, 2013. Tenderness to palpation in the thoracic and lumbar regions was noted. Range of motion of the spine was noted to be decreased. Straight leg raise testing elicited pain and some lower extremity symptoms. Decreased sensation at this time was reported in an L5-S1 distribution. Motor strength was noted to be decreased in the bilateral lower extremities secondary to back pain. The treating provider is requesting an IRO to evaluate the previously non-certified request for a lumbar epidural steroid injection at the L5-S1 level with epidurography and lysis of adhesions.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division Mandated Official Disability Guidelines, lumbar epidural steroid injections are supported in individuals that have objective or clinical evidence of a lumbar radiculopathy, which consists of decreased strength in a specific myotomal pattern, loss of sensation in a specific dermatomal pattern, and loss of deep tendon reflexes. At this time, the physical examination findings clearly do not demonstrate clinical evidence of a lumbar radiculopathy. The claimant is noted to have some new findings of decreased sensation in an L5-S1 distribution. There is no specific documentation of loss of strength in a specific myotomal pattern or changes in reflexes to support clinical evidence of a lumbar radiculopathy and support an epidural steroid injection. Additionally, treatment guidelines would not support an epidural steroid injection unless there were corroborating imaging studies documenting neural compression. The MRI study of the lumbar spine accomplished on August 30, 2012, did document a disc protrusion at the L5-S1 level; however, there was no significant neural compression associated with this disc protrusion.

Previous requests for the same procedure have been reviewed and were noted to be non-certified based on the fact that the physical examination findings did not document any clinical evidence of a lumbar radiculopathy. Due to lack of clinical evidence of a lumbar radiculopathy, the previous request for the same procedure was not certified. The treating provider has provided an additional clinic note from January 22, 2013. Again, there is still no significant evidence of a clinical radiculopathy on physical examination findings. There is a new documentation of decreased sensation in an L5-S1 dermatome. This additional information does not result in an overturn of the previous non-certification. At this time, due to the fact that there is lack of clinical radiculopathy on objective physical examination findings at the lumbar spine at the L5-S1 level and no corroboration of any neural compression at the L5-S1 level on imaging studies, the treating providers' request cannot be certified. It should also be noted that the additional procedures of a lysis of adhesions is under study and not supported by treatment guidelines and an adhesiolysis procedure is only supported for radicular pain. There also should be documentation of scarring around the nerve to support this procedure. The imaging study does not document any sort of scarring or prior history of back surgery to support the medical necessity of a lysis of adhesions procedure. Again, since this is still not recommended due to lack of sufficient literature evidence based on Official Disability Guidelines, the request for lysis of adhesions cannot be certified. The recommendation is to uphold the previous non-certification for the medical necessity of a lumbar epidural steroid injection at the L5-S1 level with fluoroscopy, epidurography, and lysis of adhesions. Official Disability Guidelines Low Back (updated November 28, 2012)

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. 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). 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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)