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**DATE OF REVIEW:** 01/28/2011

**IRO CASE #:**

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

LESI L5-S1 (62311, 77003, 72275,62264)

**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 Neurological Surgery, Spinal 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:

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
LESI L5-S1 (62311, 77003, 72275,62264)	62311, 77003, 72275, 62264	-	Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**


**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a whose date of injury is xx/xx/xx. On this date, the patient was involved in a motor vehicle accident wherein he was struck from behind by another vehicle; airbags did not deploy. Radiology report of

the lumbar spine dated 07/27/10 indicates that the views are negative for fractures or gross osteopathology. The vertebral bodies and posterior elements are intact. The disc spaces are well maintained. The patient presented on 07/19/10 with complaints of pain and discomfort of his shoulder, low back and neck. He requested a change in medication as Motrin upsets his stomach. On physical examination, there is mild to moderate tenderness to palpation to the lumbar spine. Straight leg raising is negative bilaterally. Patellar and ankle reflexes are present. Neurosensory is grossly intact and muscle strength is rated as 5/5 throughout the lower extremities. Impression is cervical spine sprain, lumbosacral spine sprain, and right shoulder sprain. Consultation dated 08/09/10 indicates that the patient is currently attending therapeutic activities and reports that he is minimally improving. Physical examination is unchanged. CT of the lumbar spine dated 10/08/10 revealed minimal predominantly anterior sided degenerative disc disease at L5-S1 as well as mild bilateral facet degenerative changes resulting in bilateral neural foraminal narrowing with abutment of both exiting L5 nerve roots. There is no significant spinal canal narrowing. Physical examination on 10/27/10 is unchanged. Orthopedic consult by Dr. on 11/22/10 indicates that on physical examination patellar reflexes are 2%2B and symmetric bilaterally; his Achilles reflexes are not elicitable. The patient has decreased range of motion with flexion and extension limited by pain. He has a positive straight leg raise on the right. Motor strength is weakened in both lower extremities. He has decreased sensation in the lateral aspect of his right lower extremity. Physical examination on 11/24/10 again notes negative straight leg raising bilaterally, intact motor and sensory exam and symmetric deep tendon reflexes. Initial request for LESI L5-S1 was non-certified on 12/03/10 noting a lack of information regarding prior treatment and a plan to have the patient participate in an independent exercise program in conjunction with the procedure. The non-certification was subsequently upheld on appeal on 12/22/10 noting a lack of information regarding optimized conservative therapy, no PT progress reports or provider's interim progress reports.

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

Based on the clinical information provided, the request for LESI L5-S1 is not recommended as medically necessary. IRO recommends that the two previous denials are upheld. The patient sustained injuries in however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review to establish that the patient has been unresponsive to conservative care as required by current evidence based guidelines. Additionally, the patient presents with conflicting physical examinations as each consultation with Dr. notes negative straight leg raising bilaterally, intact motor and sensory exam and symmetric deep tendon reflexes; however, Dr. physical examination noted positive straight leg raise on the right, decreased sensation in the lateral aspect of the right lower extremity and weakened motor strength in both lower extremities. Given the current clinical data, the requested lumbar epidural steroid injection L5-S1 is not indicated as medically necessary. IRO recommends that the two previous denials are upheld.

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.)

**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)

**TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS:** The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with 28 TAC §12.206(d)(19), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 01/26/2011.