



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 8-6-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

62282 Lumbar epidural steroid injection at L4-L5 and L5-S1, 62319 additional level, 62284 Myelogram, 72275 epidurography, 99144 sedation.

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

American Board of American Board of Anesthesiology and Pain 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MD., office from 8-29-07 through 7-15-09.

Physical Therapy from 8-31-07 through 6-16-09 (15 visits)

9-26-07 MRI of the lumbar spine.

MD., office visits from 10-15-07 through 6-10-09.

MD., office visits from 6-2-08 through 7-21-09.

6-5-08 MD., Performed a Peer Review.

7-14-08 EMG/NCS performed by MD.

11-18-08 MRI of the lumbar spine.

12-17-08 EMG/NCS performed by MD.

1-26-09 X-ray of PA and lateral chest performed by MD.

1-29-09 X-ray of the lumbar spine performed by MD.

1-29-09 Surgery performed by MD.

5-13-09 MRI of the lumbar spine.

5-18-09 X-ray of the lumbar spine performed by MD.

6-1-09 EMG/NCS performed by MD.

6-24-09 DO., Utilization Review.

7-5-09 MD., Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Per The Employer's First Report of Injury, the claimant sustained a work related injury on xx/xx/xx while employed . On this date, the claimant reported that he was re-adjusting a bike rack-pins hook and fell through the bike rack.

Xx/xx/xx MD., Claimant complains of lower back pain. Claimant has a knot on his back. The claimant reported that he was re-adjusting a bike rack-pins hook and fell through the bike rack. Assessment: lumbar strain. Plan: claimant was prescribed Ultram and Flexeril, recommended physical therapy. DWC-73: claimant was returned to work from 8-29-07 through 9-5-07 with restriction. Diagnosis: lumbar strain.

Physical Therapy from 8-31-07 through 6-16-09 (15 visits)

9-12-07 MD., Claimant returned for follow up visit on his lumbar strain. Claimant states that the Ultram and Flexeril made him sick; claimant complains of numbness, tingling and palpable spasms in right lower back. Assessment: lumbar strain. Plan: claimant was prescribed Skelaxin. DWC-73: claimant was returned to work from 9-12-07 through 9-16-07 with restriction. Diagnosis: lumbar strain.

9-17-07 MD., Claimant returned for follow up visit on his lumbar strain. Claimant states that he feels worse and that the pain extends to his right knee, the pain is constant and sharp. Assessment: lumbar strain. Plan: claimant was prescribed Toradol and Darvocet, continue therapy, evaluator recommended an MRI. DWC-73: claimant was taken off work from 9-17-07 through 9-24-07. Diagnosis: back pain.

9-24-07 MD., Claimant returned for follow up visit on his lumbar strain. Claimant states that he has constant, severe shooting pain down posterior to right thigh to the knee. Assessment: lumbar pain radiculopathy. Plan: claimant was prescribed Toradol, recommended an MRI. DWC-73: claimant was taken off work from 9-24-07 through 9-29-07. Diagnosis: lumbar pain radiculopathy.

9-26-07 MRI of the lumbar spine performed by MD., showed mild spondylosis of the LS spine from the level of L3 through S1, findings at different disc levels, mild spinal stenosis at L4-5 and L5-S1 levels.

9-28-07 MD., Claimant returned for follow up visit on his lumbar strain. Claimant complains of lower back pain, sharp pain that extends from lower back to right leg. Assessment: back pain, spinal stenosis, radiculopathy. Plan: claimant was prescribed Toradol, Ibuprofen and Medrol Dosepack. DWC-73: claimant was taken off work from 9-28-07 through 10-26-07. Diagnosis: back pain, radiculopathy.

10-15-07 MD., Claimant presents for an evaluation and treatment on his low back pain. Claimant complains of severe pain, excruciating, and intractable, claimant does have

radiation of pain into the right lower extremity; claimant appears to follow the posterior lateral aspect of his leg. Claimant states that physical therapy made him worse and any sort of activity makes his pain worse and constant. Current medications: Actoplus, Folbic, Vytarin, Skelaxin, Propoxy APAP, Methylpred, and Tramadol. Assessment: low back pain with right greater than left lower extremity radiculopathy. Plan: claimant will be scheduled for an ESI in the lumbar spine at L5-S1, which is medically indicated and medically necessary.

10-29-07 MD., Claimant returned for follow up visit on his lumbar strain. Claimant continues to complain of severe pain from back to right foot, also numbness in groin area. Assessment: back pain, radiculopathy, spinal stenosis. Plan: claimant is scheduled for an ESI on 11-2-07, follow up with Dr. DWC-73: claimant was taken off work from 10-29-07 through 11-29-07. Diagnosis: back pain, radiculopathy, spinal stenosis.

11-6-07 MD., the evaluator noted that the claimant has been using the RS-2m muscle stimulator for rehabilitation, which has helped alleviate painful symptoms due to the diagnosis of lumbago.

11-19-07 MD., Claimant returned for follow up visit on his spinal stenosis, radiculopathy. Claimant states that his pain is improved since the ESI, but still has some pain shooting down his buttocks. Assessment: back pain, radiculopathy, spinal stenosis. Plan: follow up with Dr. DWC-73: claimant was returned to work from 11-19-07 through 12-19-07 with restriction. Diagnosis: back pain, radiculopathy, spinal stenosis.

11-23-07 MD., DWC-73: claimant was returned to work from 11-23-07 through 12-19-07 with restriction. Diagnosis: back pain, radiculopathy, spinal stenosis.

12-20-07 MD., Claimant returned for follow up visit on his low back pain. Claimant complains of severe pain, excruciating, and intractable, claimant does have radiation of pain into the right lower extremity; claimant appears to follow the posterior lateral aspect of his leg. Assessment: low back pain with right greater than left lower extremity radiculopathy. Plan: claimant will be scheduled for an ESI in the lumbar spine at L5-S1, which is medically indicated and medically necessary.

12-20-07 MD., Preoperative and Postoperative Diagnosis: low back pain with lower extremity radiculopathy. Procedure: caudal epidurogram myelogram without dural puncture, caudal epidural catheter placement with injection of epidural steroid at L5-S1 on the right side Racz Tun-L catheter, nerve root decompression at L5-S1 on the right side, interpretation of radiograph.

1-3-08 MD., Claimant returned for follow up visit on his spinal stenosis, radiculopathy. Claimant states his pain is worse shooting down his right leg. Claimant had minimal relief from his last ESI. Assessment: back pain, radiculopathy. Plan: follow up with Dr. DWC-73: claimant was returned to work from 1-3-08 through 1-31-08 with restriction. Diagnosis: back pain, radiculopathy, spinal stenosis.

1-25-08 MD., Claimant returned for follow up visit on his low back pain. Claimant continues to complain of low back pain with lower extremity radiculopathy, most of his pain isolated to the lumbar spine. Assessment: low back pain secondary to facet pain at this time. Plan: recommend the claimant proceed with bilateral facet injections in the lumbar spine, continue with current medications.

2-12-08 MD., Claimant returned for follow up visit on his back pain, radiculopathy. Claimant states his pain is still shooting down his right leg, claimant had minimal relief from his last ESI, his facet injections have been denied. Assessment: back pain. Plan: follow up with Dr. DWC-73: claimant was returned to work from 2-12-08 through 4-10-08 with restriction. Diagnosis: back pain, radiculopathy.

4-7-08 MD., Claimant returned for follow up visit on his back pain, radiculopathy. Claimant states his condition is not improving, claimant has constant pain shooting down his right leg, claimant quality of life and work capacity is very limited. Current medications: Skelaxin, Ibuprofen, Celebrex, Darvocet, Glipizide, Cymbalta. Assessment: back pain, radiculopathy. Plan: recommended an EMG/NCS. DWC-73: claimant was returned to work from 4-7-08 through 5-6-08 with restriction. Diagnosis: back pain, radiculopathy.

6-2-08 MD., Claimant presents with complaints of back pain, right buttock pain, right lower extremity radicular pain, weakness, and numbness in the foot, claimant walks with a limp secondary to pain and cannot bend or twist because of pain. Assessment/Plan: claimant appears to have weakness in the right dorsi and plantar flexion of the foot and a straight leg raise that is positive at 10 degree. The weakness in the claimant's foot is trace and it is hard to get a good idea of his strength secondary to the pain on confrontational testing. Evaluator recommends an EMG/NCS.

6-3-08 MD., Claimant returned for follow up visit on his back pain, radiculopathy. Claimant states he still has constant pain shooting down his right leg. Assessment: back pain, radiculopathy. Plan: continue current medications and follow up with Dr. DWC-73: claimant was returned to work from 6-3-08 through 7-11-08 with restriction. Diagnosis: back pain, radiculopathy.

6-5-08 MD., Performed a Peer Review. It was his opinion based upon the description of the occupational injury and given the medical management that the claimant has had over the past year and given the fact that xxxx year has already passed since the occupational injury, reasonably, any contusions, strains or sprains or any time-limited exacerbation of underlying lumbar arthritis would have resolved and would not necessitate ongoing medical management, at this juncture, in June 2008. The evaluator reported he could not recommend ongoing physician visits unless they are undertaken to wean off prescription medications. After the claimant wean off all prescription medications, additional follow up visits would not be medically necessary. Additionally, the claimant is not a candidate for rehabilitation as far as physical therapy and/or chiropractic and similar are concerned.

7-14-08 MD., the evaluator noted that the claimant does indeed have a right S1 radiculopathy on his EMG/NCS from July 14th indicating moderate denervation changes in the right medial gastrocnemius, extensor hallucis longus, and lower lumbar paraspinals. This is concordant with his right lower extremity radicular pain and weakness, plantar flexion of his foot, and absent Achilles reflex. Claimant has a positive straight leg raise at 10 degree and he has failed maximal conservative treatment, physical therapy, and interventional pain management. Claimant will be scheduled for a right L5-S1 laminectomy as soon as approval.

7-14-08 EMG/NCS performed by MD., showed right S1 radiculopathy, the claimant has moderate active ongoing denervation potentials in the right S1 myotome including medial gastrocnemius, AHB, and lower lumbar paraspinal muscle.

7-17-08 MD., Claimant returned for follow up visit on his back pain, radiculopathy. Claimant states he still has constant pain shooting down his right leg. Assessment: back pain, radiculopathy. Plan: continue current medications and follow up with Dr. DWC-73: claimant was taken off work from 7-17-08 through 8-14-08. Diagnosis: back pain, radiculopathy.

7-22-08, 9-2-08, 10-7-08 MD., Claimant returned for follow up visit on his back pain, radiculopathy. Claimant states he still has constant pain shooting down his right leg. Assessment: back pain, radiculopathy. Plan: continue current medications and follow up with Dr. DWC-73: claimant was taken off work from 7-22-08 through 12-4-08. Diagnosis: back pain, radiculopathy.

11-3-08 MD., Claimant returned for follow up visit on his back pain, radiculopathy. Claimant states his condition is unchanged. Assessment: back pain, sciatica. Plan: recommended MRI of the lumbar spine. DWC-73: claimant was returned to work from 11-3-08 through 1-3-09 with restriction. Diagnosis: back pain, sciatica.

11-12-08 MD., Performed a Peer Review. It was his opinion that the claimant exam is consistent with the pathology revealed from his MRI and NCV. The claimant activity of daily living is greatly affected by this disease entity and the claimant failed conservative treatment including steroid injection. The evaluator agreed with Dr. 's assessment and it was his medical opinion that L5-S1 laminectomy should be considered as part of the treatment for his compensable injury the claimant agrees to the procedure after an informed consent is obtained by Dr.

11-18-08 MRI of the lumbar spine performed by MD., showed congenitally small spinal canal due to short pedicles, no definite spinal canal stenosis, foraminal narrowing, mild disc desiccation L5-S1, diffuse annular disc bulges L4-L5 and L5-S1.

12-17-08 EMG/NCS performed by MD., showed a right L5 radiculopathy that appears to be fairly chronic; there is no evidence of other radiculopathy or entrapment neuropathy in the bilateral lower extremities.

1-5-09, 1-12-09 MD., Claimant returned for follow up visit on his back pain, radiculopathy. Claimant states his condition is unchanged. Assessment: back pain,

sciatica. Plan: continue current medication, follow up with Dr. Current medication: Xodol, Skelaxin, Janumet, Glipizide, and Lantus. DWC-73: claimant was returned to work from 1-5-09 with restriction. Diagnosis: back pain, sciatica.

1-6-09 MD., the evaluator noted that the claimant is happy with his care but frustrated by the multiple denials from his insurance. Evaluator recommended a new EMG prior to considering surgery given the new left sided symptoms. Assessment: thoracic or lumbosacral neuritis or radiculitis, unspecified, laminectomy, lumbar.

1-26-09 X-ray of PA and lateral chest performed by MD., showed negative chest.

1-29-09 X-ray of the lumbar spine performed by MD., showed a surgical probe posterior to the L4-L5 disc space, this assumes five lumbar type vertebral bodies.

1-29-09 MD., Preoperative and Postoperative Diagnosis: lumbar radiculopathy. Procedure: bilateral L4-5 laminectomy with microscope.

1-30-09 MD., the evaluator noted that the claimant returned for follow up visit on his back pain. Claimant states that he is still having bilateral lower extremity radicular pain despite maximal conservative treatment. Evaluator recommended a bilateral L4-5 laminectomy and proceeds as soon as approval. Assessment: thoracic or lumbosacral neuritis or radiculitis, unspecified, laminectomy, lumbar.

2-17-09 09 MD., the evaluator noted that the claimant returned after a 2 week routine lumbar laminectomy. Sutures were removed and the wound is clean, dry and intact. At this time evaluator will schedule a 6 week postop visit and see if there is any need for physical therapy at that time, otherwise, things look good.

2-23-09 MD., Claimant returned for follow up visit on his back pain. Claimant states hi is recovering from surgery on 1-29-09, but still has low back pain extending to the buttocks, claimant is still having difficulty walking due to pain. Assessment: back pain, gait instability. Plan: claimant was given prescription for walking cane, follow up in 3 months. DWC-73: claimant was taken off work from 2-23-09. Diagnosis: back pain, gait instability.

3-24-09 MD., the evaluator noted that the claimant returned after a 6 week routine lumbar laminectomy, the wound is clean, dry and intact, neurologic exam is stable. Evaluator recommended an MRI and flex-ext x-ray, due to the claimant's continued back pain, he will start physical therapy if he isn't getting better. Assessment: thoracic or lumbosacral neuritis or radiculitis, unspecified, physical therapy referral.

5-5-09 MD., the evaluator noted that the claimant is continuing with significant mechanical back pain despite physical therapy. Evaluator will order and MRI and flex-ext x-ray. Assessment: thoracic or lumbosacral neuritis or radiculitis, unspecified, MRI, LS spine.

5-13-09 MRI of the lumbar spine and post 20cc magnevist performed by MD., showed post laminectomy changes at L4-L5 and L5-S1 with expected enhancement in the

posterior paraspinous tissues and around the dural sac, bulging disc at L4-L5 and L5-S1 with no mass effect, foraminal narrowing at L4-L5 and L5-S1, this is most pronounced on the right side at L5-S1 and there has been no change.

5-18-09, 5-29-09 MD., the evaluator noted that the claimant is complaining of low back pain that sounds mechanical and right buttock pain. The MRI really appears uncomplicated, but there does appear to be some foraminal stenosis. Evaluator will order an EMG and get the claimant his flex-ext x-ray. Assessment: thoracic or lumbosacral neuritis or radiculitis, unspecified, EMG/NCS, x-ray of lumbar spine.

5-18-09 X-ray of the lumbar spine performed by MD., showed normal lumbar spine, no abnormal motion on flexion or extension.

5-20-09 MD., Claimant returned for follow up visit on his back pain. Claimant states continue to have pain. Assessment: back pain, radiculopathy. Plan: follow up with Dr. and refer to Dr. DWC-73: claimant was taken off work from 5-20-09. Diagnosis: back pain, gait instability.

5-27-09 MD., Claimant returned for follow up visit on his back pain. Assessment: low back pain. Plan: evaluator will obtain any previous MRI's that were performed recently, evaluator will await the EMG results and see what Dr. recommends, and claimant may be a candidate for a repeat ESI.

6-1-09, 6-12-09 MD., the evaluator noted that the claimant has a mild chronic right L5 radiculopathy, which is not unusual for the first 1-2 years postop, claimant is trouble by his right buttock pain. Evaluator recommended a right L4-5 TEN and if that does not work, we could do a redo laminectomy. Assessment: thoracic or lumbosacral neuritis or radiculitis, unspecified, pain management referral.

6-1-09 EMG/NCS performed by MD., showed mild pattern of denervation in the right L5 myotome, this pattern of denervation may last up to 1-2 years post-decompression of the root, there is no worsening of the denervation noted in the extremities postoperatively. This claimant shows a mild generalized sensory/motor peripheral neuropathy most consistent with his diabetes mellitus.

6-10-09 MD., Claimant returned for follow up visit on his back pain. Claimant does have L5 radiculopathy and radicular pain extending down the lower extremity, deep tendon reflexes are hyperreflexic, there is pain on flexion, extension, and lateral motion, palpation of the spine acerbates the pain. Assessment: low back pain with lower extremity radiculopathy. Plan: recommended to proceed with an ESI, claimant will continue with medications.

6-24-09 DO., Utilization Review. The reviewer attempted to perform a Peer to Peer, but no contact was achieved. The evaluator recommended non-certification of invasive procedure in diabetic with unknown control and evidence of underlying diabetic peripheral neuropathy.

7-5-09 MD., Utilization Review. The reviewer attempted Peer to Peer, but no contact was made. The evaluator noted that records from the neurosurgeon reflects mechanical back pain, without clinical evidence of suggest or suspect a clinical reproducible radiculopathy. Repeat electrodiagnostic testing showed no new denervation. Request does not meet ODG criteria for epidural steroid injection. Additionally, the claimant was diabetic.

7-13-09 MD., DWC-73: claimant was returned to work from 7-13-09 with restrictions. Diagnosis: radiculopathy, L5-S1 disc bulge.

7-15-09 MD., DWC-73: claimant was returned to work from 7-15-09 with restrictions. Diagnosis: radiculopathy, lumbar disc bulge.

7-21-09 MD., the evaluator noted that the claimant is quite despondent over the repeated denials from his insurance for the transforaminal injections. Evaluator would not recommend further surgery and in his opinion the injections are the claimant's best option, if the claimant is denied again, it would be best for his treating doctor to set him up for an IRO, claimant will follow up in 3 months.

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

THIS PATIENT HAS HAD A LONG HISTORY OF THE LUMBAR PAIN WITH RADIATION DOWN THE LEGS. THIS PATIENT RECENTLY UNDERWENT LUMBAR SURGERY IN JANUARY OF 2009. HE CONTINUES TO DEMONSTRATE A RADICULAR COMPONENT TO HIS PAIN WITH POSITIVE EMG/NCV AND MRI FINDINGS. THE PATIENT HAS NOT HAD A PREVIOUS TRANSFORAMINAL EPIDURAL STEROID INJECTION APPROACH TO TRY TO DECREASE HIS PAIN. THERE IS DOCUMENTED FORAMINAL NARROWING AT THE L4-L5 AND L5-S1 LEVELS WHICH COULD BE CONTRIBUTING TO THE PATIENT'S RADICULAR SYMPTOMS. ACCORDING TO ODG GUIDELINES, THE TRANSFORAMINAL APPROACH WOULD BE APPROPRIATE FOR PATIENTS WITH FORAMINAL NARROWING AND RADICULAR SYMPTOMS. BASED ON THE MEDICAL RECORDS PROVIDED, IT IS MY OPINION THAT THE TRANSFORAMINAL EPIDURAL WOULD BE AN APPROPRIATE OPTION TO HELP THIS PATIENT. I DO NOT FEEL ANY OTHER EPIDURAL APPROACH SUCH AS THE TRANSLAMINAR APPROACH WOULD BE OF BENEFIT. THEREFORE, CERTIFICATION IS PROVIDED FOR LUMBAR EPIDURAL STEROID INJECTION AT L4-L5 AND L5-S1, ADDITIONAL LEVEL, MYELOGRAM, EPIDUROGRAPHY AND SEDATION IS CERTIFIED.

ODG-TWC, last update 7-28-09 Occupational Disorders of the Low Back – Epidural steroid injection: Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative

findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition.

Short-term symptoms: The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. (Armon, 2007) Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function or return to work. There is no high-level evidence to support the use of epidural injections of steroids, local anesthetics, and/or opioids as a treatment for acute low back pain without radiculopathy. (Benzon, 1986) (ISIS, 1999) (DePalma, 2005) (Molloy, 2005) (Wilson-MacDonald, 2005) This recent RCT concluded that both ESIs and PT seem to be effective for lumbar spinal stenosis for up to 6 months. Both ESI and PT groups demonstrated significant improvement in pain and functional parameters compared to control and no significant difference was noted between the 2 treatment groups at 6 months, but the ESI group was significantly more improved at the 2nd week. (Koc, 2009)

Use for chronic pain: Chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. The ideal time of either when to initiate treatment or when treatment is no longer thought to be effective has not been determined. (Hopwood, 1993) (Cyteval, 2006) Indications for repeating ESIs in patients with chronic pain at a level previously injected (> 24 months) include a symptom-free interval or indication of a new clinical presentation at the level.

Transforaminal approach: Some groups suggest that there may be a preference for a transforaminal approach as the technique allows for delivery of medication at the target tissue site, and an advantage for transforaminal injections in herniated nucleus pulposus over translaminar or caudal injections has been suggested in the best available studies. (Riew, 2000) (Vad, 2002) (Young, 2007) This approach may be particularly helpful in patients with large disc herniations, foraminal stenosis, and lateral disc herniations. (Colorado, 2001) (ICSI, 2004) (McLain, 2005) (Wilson-MacDonald, 2005)

Fluoroscopic guidance: Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure. (Manchikanti, 1999) (Colorado, 2001) (ICSI, 2004) (Molloy, 2005) (Young, 2007)

Factors that decrease success: Decreased success rates have been found in patients who are unemployed due to pain, who smoke, have had previous back surgery, have pain that is not decreased by medication, and/or evidence of substance abuse, disability or litigation. (Jamison, 1991) (Abram, 1999) Research reporting effectiveness of ESIs in the past has been contradictory, but these discrepancies are felt to have been, in part, secondary to numerous methodological flaws in the early studies, including the lack of imaging and contrast administration. Success rates also may depend on the technical skill of the interventionalist. (Carette, 1997) (Bigos, 1999) (Rozenberg, 1999) (Botwin, 2002) (Manchikanti, 2003) (CMS, 2004) (Delpont, 2004) (Khot, 2004) (Buttermann,

2004) (Buttermann2, 2004) (Samanta, 2004) (Cigna, 2004) (Benzon, 2005) (Dashfield, 2005) (Arden, 2005) (Price, 2005) (Resnick, 2005) (Abdi, 2007) (Boswell, 2007) Also see Epidural steroid injections, "series of three" and Epidural steroid injections, diagnostic. ESIs may be helpful with radicular symptoms not responsive to 2 to 6 weeks of conservative therapy. (Kinkade, 2007) Epidural steroid injections are an option for short-term pain relief of persistent radiculopathy, although not for nonspecific low back pain or spinal stenosis. (Chou, 2008) As noted above, injections are recommended if they can facilitate a return to functionality (via activity & exercise). If post-injection physical therapy visits are required for instruction in these active self-performed exercise programs, these visits should be included within the overall recommendations under Physical therapy, or at least not require more than 2 additional visits to reinforce the home exercise program.

With discectomy: Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. (Rasmussen, 2008)

An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. (Staal-Cochrane, 2009) Recent studies document a 629% increase in expenditures for ESIs, without demonstrated improvements in patient outcomes or disability rates. (Deyo, 2009) There is fair evidence that epidural steroid injection is moderately effective for short-term (but not long-term) symptom relief. (Chou3, 2009)

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, 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)

(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 required. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of 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)**