



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 11-9-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Caudal epidural steroid injection with lysis of adhesions plus MAC 62311, 62264, 77003

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

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

- 6-8-05 MRI of the lumbar spine.
- 5-22-09 MRI of the lumbar spine.
- 8-6-09 MRI of the lumbar spine.
- MD., office visits on 8-12-09, 9-21-09, 11-30-09, 1-18-10, 1-27-10, 2-15-10, 3-3-10, 4-7-10, 5-21-10, 6-14-10,
- Physical therapy on 8-21-09, 8-27-09 and 8-28-09.
- 12-15-09 MD., office visit.
- 3-23-10 MD., performed a Required Medical Evaluation.
- 4-20-10 MD., office visit.
- MD., office visits on 6-9-10, 6-24-10 and 9-9-10
- 6-10-10 CT scan of the lumbar spine post myelogram.
- 6-10-10 Lumbar myelogram.
- 6-30-10 UDS.
- 8-3-10 MD., office visit.
- 8-16-10 MD., performed a Designated Doctor Evaluation.
- 8-27-10 MD., performed a transforaminal epidural steroid injection at L3-L4 and L4-L5.
- 10-4-10 DO., performed a Utilization Review.

- 10-10-10 MD., provided an Appeal/Reconsideration for denied procedure.
- 10-22-10 MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

6-8-05 MRI of the lumbar spine shows equivocal enhancement of epidural soft tissues at the level of L3-L4 disc space and posterior elements of L3. This is just above the pedicle screws at the L4 level and may represent an artifact associated with the metallic foreign material or inflammation. No evidence of mechanical compression of the thecal sac or abnormal fluid collection. Pedicle screws from L4 to S1 with instrumentation at the L4 and L5 and fusion at the L4-L5 and L5-S1 disc space.

5-22-09 MRI of the lumbar spine shows post surgical change involving the lower lumbar spine. Posterior decompression has taken place. Central disc herniation at L3-L4 causing flattening of the thecal sac.

8-6-09 MRI of the lumbar spine showed status post L4-L5 laminectomy with posterior fusion of the L4 though S1 vertebra. The hardware is well seated. The vertebra are well aligned. Mild to moderate lumbar spondylosis and disc disease.

8-12-09 MD., the claimant Overall she is still having the pain in her back, down into her legs that is bothering and giving her difficulty, it is there on a day to day basis to the point where she is really having a hard time living with it. She has been trying to exercise and trying to take her anti-inflammatories but it bothers her. Today on her physical exam her reflexes are 1 throughout. Motor groups are 5. Toes are downgoing. No clonus. Plan: try her on some Lyrica to see if it will give her some relief of her symptoms. She is going to walk 40 minutes which she has been trying to do, do her back exercises because of the amount of leg symptomatology with the lateral recess narrowing, and the stenosis that she has at 3-4 above. He was going to try an epidural to see if it will give her some relief where she can then exercise and work out. He would like to see her back two to three weeks post the injection. She needs to remain off of work in the meantime.

Physical therapy on 8-21-09, 8-27-09 and 8-28-09.

9-21-09 MD., the claimant reports overall her back is still bothering her. She re-injured it in January of this year and has the pain in her back and down into her legs since that time. Today on her physical exam her neurologic exam remains intact. Her left EHL is 4/5. She is hyporeflexic at her ankles and knees. Toes downgoing. No clonus. The evaluator reported that known her over the last several years. She has worked diligently at her job and occupation. She had a fusion done on her back in 2000 and has worked every day since then. She is having pain where she cannot sit, stand or walk for any period of time without difficulties. She has tried medicines, physical therapy and exercises, trying an epidural to see if would give her same relief where she can get back to work and doing her job and occupation is reasonable. At the current time she cannot

sit. He had taken her off of work for the next two months to give worker's comp time to improve this. They have already denied it once on appeal. He would like to reevaluate her in another four week period of time to determine her status. She has also been on some Prozac to try to help her with depression. She does not have any suicidal or other thoughts in regards to this, but does feel severely depressed between her financial status, worker's compensation, delay of her care and her overall status in regards to this, which is reasonable under her circumstances.

Follow up with Dr. on 11-30-09 notes that once again he was going to try to obtain an epidural and see if it will give her some relief of her symptoms to try to allow her to return back to her job and occupation. Worker's compensation has put this patient under significant duress because of the continued delay for her care. He was also going to send her to see one of the psychiatrists for evaluation for her depression to have this treated. She has not had any true suicidal ideas but has been very depressed and does not where to proceed forward or where to go because of the delays with worker's comp and the financial difficulties she is having. He would like to see her back two weeks after the injection has been improved and completed. In the interim will try to get her some psychological help in regards to this. He did believe this is directly related to worker's compensation and the delay in care from worker's compensation and the secondary issues involved with this.

On 12-15-09, the claimant was evaluated by MD., the claimant Patient is a woman who is right handed and right footed. The patient is being seen at the request of M.D. for evaluation of pain symptoms and medication management. The patient states that she was injured at work on xx/xx/xx. She was lifting computers. She was working in the xx. She was lifting and twisting. She had the onset of low back pain. The pain did radiate into her legs and feet, both legs equally. She did have pain in the posterior lateral aspect of the legs. She also had some numbness and a warm-like sensation in both lower legs laterally and anteriorly. She felt some weakness occasionally in her legs. Low back pain, at times, would radiate superiorly in the mid thoracic area. The patient has had some occasional occipital headaches. She did have some blurred vision when she was put on Lyrica. No dizziness or vertigo. No incontinence to urine or stool. On exam, 5/5 strength in both arms and legs. Heel to knee to shin movements are intact, Muscle tone, +2 in both arms and both legs. Sensory Exam: Intact to pin point and light touch. Reflexes: +2 at the biceps, +1 at the wrist, 0 both triceps, 0 both knees, 0 both ankles. Treatment: continue Prozac, Robaxin and Lyrica.

Follow up with Dr. on xx/xx/xx notes the claimant has been out of work and had a psychosocial weaning and has been cleared for surgery. She has stenosis and radiculopathy in her leg consistent with this. The evaluator discussed with them at length the pluses and minuses and the reasons for proceeding forward in this fashion and alternative forms of treatment. He changed his mind and suggested possible epidural steroid injections which have been repeatedly fused.

Follow up with Dr. on 2-15-10 notes the evaluator recommended proceeding forward with further treatment.

Follow up with Dr. on 3-3-10 notes the claimant could work at a job.

On 3-23-10, MD., performed a Required Medical Evaluation. It was his opinion that there is no evidence of any nerve root compression documented in the accompanying medical records. In particular, there are two imaging studies neither of which shows evidence of nerve root compression. The second imaging study actually shows what could be interpreted as an improvement in that the disc abnormality at L3-L4 is now measured as only 1 mm whereas on 5/22/2009 it was reported to be 4-5 mm. In any case, there was no documentation of any nerve root compression that would produce a lumbar radiculopathy. Furthermore, the medical records do not document any focal motor weakness, reflex loss or atrophy. Today's examination likewise did not document any focal motor weakness or focal reflex loss that would allow a physician to make a diagnosis or a radiculopathy at the L3-L4 level.

4-7-10 Follow up with Dr. notes he discussed the case with the claimant and his feelings regarding this case. The claimant was continued with her medications.

4-20-10 MD., the claimant has not entered a pain management program. There continue to be issues about her insurance coverage and compensable diagnosis. Examination continues to show the old incision is well healed. She has marked tenderness in the paraspinal muscles. Range of motion is limited with only 20 degrees of flexion. She has hack pain with straight-leg raisins, but there are no true nerve root tension sips. There is good strength in the iliopsoas, quadriceps, tibialis anterior, extensor hallucis longus, gastrocnemius, and soleus group. Reflexes are normal. He gave her another prescription for pain management.

5-21-10, MD., the claimant is still having symptoms down in her back and down into her legs. She has had some pain in her back, into her buttocks and numbness down into her feet. She has pain in her back when she stands and walks with some pain and some heaviness down into her legs. Today on her EHLs is 3/4. Reflexes are 1. Toes are downgoing. No clones. Pulses are 1. She has been medically cleared. She does not smoke. She does not take narcotics. She has attempted conservative medicines, exercises, and attempted to have injections done to try to give her relief of her symptoms all of which have failed. She has had progressive symptomatology into her lower extremities which is limiting her function and ability to work on a day to day basis. She has been psychologically cleared to proceed forward with surgical intervention. Workers' Comp. continues to delay her care and appropriate treatment with some progression of the numbness into both of the lower extremities secondary to the stenosis. She needs to proceed forward with surgical intervention. She has applied for social security disability. He refilled her medications.

6-9-10 MD., the claimant presents today for a pain management evaluation after being referred to us by Dr. Stephen asses, The patient was injured on the job on xx/xx/xx when she was lifting a computer that weighed around an estimated 40 lbs at work when she felt a sudden severe onset of lower back pain with radiation to the bilateral lower

extremities. She currently rates her pain a 10 on a scale of 10 in intensity describing it as deep, constant, aching, burning, shooting, stabbing, tingling, and numbing in nature', made worse with sitting, standing, walking, bending, coughing, sneezing, and lying down; made better by nothing. The patient does complain of radiation of the lower back pain in the bilateral lower extremities with associated numbness and tingling to her toes and associated weakness. She states that she has been suffering from insomnia due to her pain complaints and underwent physical therapy, which she states did not help. She does have a history of a previous lumbar fusion at the L4-L5 level being performed in 2000. The patient is currently being maintained on a medication regimen of Vicodin 5/500 two to three times a day, Skelaxin 800 mg one pill twice a day for muscle spasms, and Lyrica twice daily for her neuropathic pain complaints. She does complain of some depression. On exam, the claimant has positive Patrick's test bilaterally, positive sacroiliac joint tenderness. Positive Gaalen's test bilaterally. Strength is decreased in the right lower extremity 3/5 in hip flexion. Strength, on the right is maintained 5/5 in hip flexion, dorsiflexion is decreased on the left 4/5 and maintained in extensor hallucis longus 5/5. DTR are depressed bilaterally. The evaluator reported that after clinical evaluation of the patient and review of her diagnostic studies, the patient continues to have L3-L4 radiculopathy, right side greater than left as well as positive findings on MRI of L3-L4 disc herniation. The patient has not benefited at the current time from her physical therapy due to her pain complaints and at this time her medications are not providing her with much relief either. He recommended at this time she undergo a series of right-sided transforaminal lumbar epidural steroid injections at the levels of L2-L3 and L3-L4. Since her pain is worse on the right side than the left side, he will address her right-sided symptoms at this time. She is to continue her Vicodin and he will increase it to 7.5/500 one pill three times a day prn pain with a two-week supply, #45. She is also to continue her Skelaxin as prescribed and the patient will follow-up in our office upon further medical decision making based upon the results of her injection.

6-10-10 CT scan of the lumbar spine post myelogram showed at L1-L2, mild disc degeneration. No central canal or foraminal stenosis. At L2-L3, mild disc degeneration. No central canal stenosis. No foraminal stenosis. At L3-L4, mild disc degeneration. 2 mm disc bulging. Mild central canal stenosis. Mild foraminal stenosis. At L4-L5, patient is status post anterior discectomy and laminectomy. There is solid interbody fusion. No foraminal stenosis. At L5-S1, patient is status post anterior discectomy and laminectomy. There is solid interbody fusion. No foraminal stenosis.

6-10-10 Lumbar myelogram showed a small ventral extradural defect is present at the L3-L4 level. The lumbar nerve roots are adequately filled.

Follow up with Dr. on 6-14-10 notes the claimant is frustrated regarding her back. The evaluator reported that if she feels she can return to her job and occupation, he encouraged her to do so. She worked for 10 years after her last fusion, but at this time she cannot sit for a long enough period of time. The evaluator recommended trying to obtain a discogram.

Follow up with Dr. on 6-24-10 notes the claimant was provided with a refill for Vicodin, and Amrix. He recommended a TENS unit.

6-30-10 UDS was negative for Hydrocodone and Hydromorphone. It was positive for ethanol and ethyl glucuronide.

8-3-10 MD., the claimant complains of low back and bilateral lower extremity pain. Symptoms have worsened since 1-27-09. On exam, the claimant has no evidence of weakness in bilateral L1-S1. DTR are 0+/5 patella and Achilles. The evaluator recommended lumbar discogram and post CT scan.

8-16-10 MD., performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI and estimated 10-30-10 as the date of MMI. The evaluator reported that the orthopedist has requested pre authorization for surgery of L2-L3 due to spinal stenosis x 2, but denied because she has not had lesser procedures. She had conservative therapy for 1 ear. Repeated requests for epidural steroid injection has been repeated denied. She has had an EMG which showed positive findings. Recommend she be approved for lumbar epidural steroid injection. If not beneficial, most likely will require the recommended surgery.

On 8-27-10 MD., performed a transforaminal epidural steroid injection at L3-L4 and L4-L5.

9-9-10 MD., the claimant presents today for a pain management evaluation complaining of severe pain she rates a 9 on a scale of 10 in intensity as a result of an on-the-job injury in which she injured herself while lifting computers on xx/xx/xx. She currently describes her pain as constant aching, burning, shooting, stabbing, tingling, and numbing in nature; made worse with sitting, standing, walking, bending, coughing, sneezing, and lying down; made better by nothing, The patient is currently taking Vicodin 10/650 one pill three times a day for pain, Zipsor 25 mg one pill three times a day for pain and inflammation and Neurontin 300 mg one pill three times a day for her neuropathic pain complaints. The patient recently underwent a right sided transforaminal lumbar epidural steroid injection at the levels of L3-L4 and L4-L5, which provided her no relief. In addition to her back pain, the patient also complains of weakness, fatigue as well as tingling. She is currently not working because of her pain complaints, continues to complain of insomnia due to her pain complaints as well as a decrease in her activities of daily living. The patient does not exhibit any aberrant drug behavior and does not report any side effects as a result of her medications or injections. On exam, Lumbar Spinous Process Tenderness: Palpated from L3 through S1. Facet Column Tenderness: Palpated from L3 through S1. ROM: Decreased with pain upon bilateral axial loading. SLR: Positive straight leg raise test on the right. Muscle Spasms: Palpated in the right lumbosacral muscles. SI Tenderness: Palpated bilaterally. Strength: Decreased 4/5 in the bilateral lower extremities, right greater than left. Sensorium: Grossly intact. Diagnosis: Lumbar HNP/disc bulge, lumbar radiculitis and lumbar post laminectomy syndrome. Plan: After clinical evaluation of the patient and once again review of her diagnostic studies, the patient had no relief from her

previous lumbar epidural steroid injection. This outcome is most likely due to fibrosis as she has undergone previous two surgeries in her lumbar spine in the past and I do believe that these adhesions are causing absorption of the steroid not to be complete. Therefore, he recommended a caudal epidural steroid injection with lysis of adhesions in order to allow an avenue for the steroid to permeate the scar tissue reaching the irritated nerves providing her with hopefully significant relief, so she may be able to perform her normal activities of daily living. Therefore, he did believe this procedure is medically reasonable and necessary. In the meantime, he will prescribe her Tramadol ER 200 mg one pill daily for pain quantity #30. She is to continue her Hydrocodone 10/650 one pill three times a day for pain with quantity of #90. He will also prescribe her Amrix 50 mg one pill a day for pain as well. He also discussed with her the results of her urine toxicology screening on today's visit as well and will perform a repeat urine toxicology screening on today's visit as well.

10-4-10 DO., performed a Utilization Review. He reported that Reviewer comments: The appropriateness and the medical necessity of Caudal Epidural Steroid Injection with IV Monitored Anesthesia Care (62311 62264 77003) are not established. The patient was last seen on 9/9/10 which showed that the patient presented with severe pain she rated at 9/10 in VAS score. The pain is currently described as constant, aching, burning, shooting, stabbing, tingling, and numbing in nature. It was also mentioned that the patient underwent Epidural Steroid Injection at L3-4 and L4-5 with no relief. Physical examination showed lumbar spinous tenderness, decreased range of motion with pain upon bilateral axial loading. The Straight Leg Raise test is positive on the right side. SI is tender bilaterally to palpation. The provider stated that the patient has failed previous Epidural Steroid Injections and stated that the outcome is most likely from the fibrosis when the patient has undergone two previous surgeries in the lumbar spine. The rationale for this request is to allow an avenue for the steroid to permeate the scar tissue reaching the irritated nerves providing the patient with significant relief of symptoms. However, the duration and percentage of pain relief from the previous Epidural Steroid Injections are not provided. In addition, there is limited objective documentation that the patient has indeed failed conservative management following the last Epidural Steroid Injection. This shall include the utilization of Physical Therapy, medications and exercises. Therefore, for these reasons, this request is not substantiated at this time. Determination: Non-Certified.

10-10-10, MD., provided an Appeal/Reconsideration for denied procedure. He noted that he felt that it was medically reasonable and necessary caudal epidural steroid injection for her continuing pain complaints of lower back pain with radiation into her bilateral lower extremities. The patient last followed up in our office on September 9, 2010, continuing to complain of severe pain she rated a 9 on a scale of 10 in intensity as a result of an on-the-job injury she sustained on xx/xx/xx, when she was lifting computers. She currently is describing her pain as constant, aching, burning, shooting, stabbing, tingling, and numbing in nature; made worse with sitting, standing, walking, bending, coughing, sneezing, and lying down; made better by nothing. She is currently on a medication regimen consisting of Vicodin 10/650 one pill three times a day for pain, Zipsor 25 mg one pill three times a day for pain and inflammation, and Neurontin 300

mg one pill three times a day for neuropathic pain. The patient does have a history of previous lumbar spine surgery on her clinical examination on her last follow-up, did have decreases in strength 4/5 in the bilateral lower extremities right greater than left as well as palpable spinous process tenderness and palpable facet column tenderness from the levels of L3 through S1 bilaterally. The patient has decreases in range of motion upon bilateral axial loading and a positive straight leg raise test on the right. A previous MRI of the lumbar spine that was performed on June 8, 2005, reveals equivocal enhancement of epidural soft tissues at the level of L3-1.4 disc space and posterior elements of L3 just above the pedicle screws at the L4 level and may represent artifact associated with metallic foreign material inflammation. Pedicle screws from L4 to S1 with laminectomies at L4 and L5 and fusions at the L4-L5 and L5-S1 disc spaces is also identified- An Nal of the lumbar spine performed on May 22, 2009, reveals at L3-L4, a broad-based central disc herniation of approximately 4-5 mm, demonstrating and causing flattening of the thecal sac along the ventral surface. At L4-L5, once again posterior decompression. At L5-S1, posterior decompression. With these findings, he did believe it does show enough evidence along with the patient's clinical examination to warrant the medical necessity of a caudal epidural steroid injection with the addition of a lysis of adhesions procedure due to once again the patient's subjective pain complaints, my clinical objective findings on physical examination, diagnostic studies that are concordant with the patient's reported pain, previous medical history that does include lumbar spine surgery, and failure of all other conservative treatment measures up to this point. At this point, the patient is being treated conservatively with minor opioid medications. At this time, I do not wish to place her on a major opioid such as Oxycontin or methadone in order to control her pain complaints. He did believe that this procedure would be the most conservative approach to treating her at this time.

10-22-10 MD., performed a Utilization Review. This is an appeal request for caudal ESI with lysis of adhesions and monitored anesthesia care. As per medical report dated 9-9-10, the patient described the pain as constant, aching, burning, shooting, stabbing, tingling, and numbing in nature. On physical examination, there is lumbar spinous tenderness, decreased range of motion with pain upon bilateral axial loading. The Straight Leg Raise test is positive on the right side. SI is tender bilaterally to palpation. Upon review of the report, there is limited documentation of conservative treatment. There are no PT progress notes to show the patient's clinical and functional response. There is no procedural report submitted for review of the previous ESI to show the patient's response. With this, the need for the request is not substantiated at this time. Determination: Non-certified

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

MEDICAL RECORDS REFLECT THE CLAIMANT HAD A TRANSFORAMINAL EPIDURAL STEROID INJECTION ON 8-27-10. DATA DOES NOT REFLECT THE CLAIMANT MEETS ODG CRITERIA FOR A REPEAT EPIDURAL STEROID INJECTION. PER ODG, IF AFTER THE INITIAL BLOCK/BLOCKS ARE GIVEN AND

FOUND TO PRODUCE PAIN RELIEF OF AT LEAST 50-70% PAIN RELIEF FOR AT LEAST 6-8 WEEKS. THERE IS ABSENCE IN DOCUMENTATION NOTING THE CLAIMANT'S RESPONSE TO THE PRIOR EPIDURAL STEROID INJECTION, HAS HAD FUNCTIONAL IMPROVEMENT, AND DECREASE IN THE USE OF MEDICATIONS. THEREFORE, THE REQUEST FOR CAUDAL EPIDURAL STEROID INJECTION WITH LYSIS OF ADHESIONS PLUS MAC 62311, 62264, 77003 IS NOT REASONABLE OR MEDICALLY NECESSARY.

ODG-TWC, last update 10-28-10 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) (Buenaventura, 2009) 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) This RCT concluded that caudal epidural injections containing steroids demonstrated better and faster efficacy than placebo. (Sayegh, 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)