AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: MAY 8, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
LESI (62311, 77003, 72275, 62264)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
This physician is Board Certified in Physical Medicine and Rehabilitation with over 15 years of experience.

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
On XX/XX/XXXX there is a note that states steel scaffold 10 foot long broke in ½ and crushed him. ER 5 day hospital with fx pelvis, herniated disc, right knee is pending surgery, partial tear of tendon in right shoulder, the remainder of the documentation is illegible.

On XX/XX/XXXX there is an initial medical report by MD. The history of the injury states claimant presents today complaining of pain at the low back, right gluteus, right shoulder, right knee, and right ankle. The claimant reports that a 1-ton hanging scaffold for use on bridges fell and struck him in the right gluteus, crushing his body against the cement barrier. Examination of the lumbar spine reveals tenderness over L4-S1. There is also tenderness over the paraspinal muscles greater on the right side. There is tenderness over the right sciatic notch. The claimant also reports having perineal pain, reportedly from fracture in the area of the pubic symphysis. Straight leg raising is positive on the right with referred pain to the right gluteus and lower extremity. There is decrease of the right S1 reflex. Also note, the claimant ambulates with a walker. The examination of the right knee reveals tenderness over the anteromedial and

anterolateral aspects. Lachman's test is negative. Internal and external torsional stresses provoke increased knee joint pain. Flexion is to 95 degrees and extension is 0 degrees. Examination of the right ankle reveals tenderness medially and anterolaterally. There is some restriction of inversion and eversion with pain. Examination of the right shoulder reveals tenderness over the lateral aspect. He can fully flex and abduct the right shoulder with pain. Flexion and abduction strength are 4/5. The diagnoses are Fracture of the pelvis x 3, Lumbar radiculitits, internal derangement of the right knee, internal derangement of the right ankle. (please note the heading for pages 2 and 3 of the report are dated 11/08/05 versus 11/08/07).

On January 7, 2008 there is an MRI of the Lumbar Spine at Clinic. The report is by MD, DABR. The findings state at L3-L4 posterior 2-3mm disc protrusion/herniation presses on the anterior thecal sac and extends laterally to create narrowing of the neural foramen bilaterally. Moderate bilateral facet hypertrophy contributes to narrowing of the lateral recess on each side no overall central spinal stenosis. At L4-L5 there is a posterior 3 mm disc protrusion/herniation presses on the anterior thecal sac and bilateral facet hypertrophy contributes to narrowing of the lateral recess on each side with no overall spinal stenosis. At L5-S1 posterior 3mm disc protrusion/herniation presses on the anterior thecal sac and medial portion of the neural foramen on each side. Bilateral facet hypertrophy contributes to narrowing of the lateral recess on each side with no overall central spinal stenosis. The conclusion states: 1. There is evidence of a transitional type vertebra at the lumbosacral junction designated as a partially lumbarized S1 segment with prominent 21-S2 interspace; 2. Using this lumbar level designation, disc pathology is scan a each of the L3-L4, L4-L5 and L5-S1 levels as described.

On January 7 2008 there is an imaging report for x-rays done of the lumbar spine, right shoulder, and right knee. AP and lateral view of the lumbar spine reveal five nonrib-bearing lumbar vertebral bodies. The disc spaces are preserved except for the L5-S1. AP and lateral views of the right knee state there is a hypertrophic change in the lateral aspect of the proximal tibia, suggestive of an exostosis. The report was written by MD, FACR.

On January 22, 2008 there is an initial examination report by MD. Per the examination the claimant has limited back extension with spasm, absent right ankle jerk, both toes go down. The right has decreased pinprick in the L4, L5, and S1 distributions. The diagnoses are Lumbar disc herniation at L3-.4, L4, l5, and L5-S1 and right lumbar radiculopathy. The recommendation was additional epidural steroids in the lumbar spine.

On April 1, 2008 there is an imaging report from Center. The report was by MD, DABR. The conclusion states there is a small amount of joint fluid present in the tibiotalar joint, there is evidence of sprain of the deltoid ligament and anterior talofibular ligament, tendinitis of the peroneus brevis tendon is seen, evidence of plantar faciitis is seen with no disruption of the plantar fascia.

On April 10, 2008 there is an operative report by MD. Preoperative diagnosis was: 1. Lumbar herniated nucleus pulposus; 2. Lumbar radiculopathy. The procedure performed was lumbar epidural steroid injection of L5-S1 done under fluoroscopy.

On April 17, 2008 there is an office visit note by PDM. The Assessment states ankle sprain with associated ankle instability and internal ankle derangement, right; foot sprain pain associated with plantar faciitis, right; tendonitis of the peroneus brevis tendon, right foot; sural neuritis, right foot.

On April 24, 2008 there is an office visit note by DPM, claimant reports since the injection at the last visit, he feels almost 50% better, continues to have pain on the plantar aspect of his right foots as well as the lateral aspect of his ankle joint. The assessment states internal ankle derangement with associated ankle instability and lateral ligament pain right; sinus tarsi syndrome, right foot; tendonitis, right ankle joint; neuritis, right foot; foot sprain pain with associated plantar fasciitis, right foot.

On May 6, 2008 there is an office visit note by DPM. The claimant states he continues to have pain outside part of his ankle joint. Objective the claimant has minor crepitation and pain upon range of motion of the ankle joint, muscle weakness of the peroneus brevis tendon and posterior tibial tendon; positive anterior drawer sign consistent with probable rupture of the ATF ligament, pain upon palpation and manipulation, injection performed today with immediate relief. Assessment states internal ankle derangement, right; sinus tarsi syndrome, right foot; tendonitis, right foot; foot sprain, right foot.

On May 15, 2008 there is a follow up examination note by MD which states the claimant continues to complain of lower back pain. The claimant has had change predominantly pain in the right leg. He has had epidural steroids and had ESI headache treated with medication. Objective states neurologic right leg positive for straight leg raise testing, motor function EHL 4/5 on the right, sensory decreased pinprick at L5. The assessment states claimant has a diagnosis of lumbar disc herniation at L4-L5, L5-S1, some at L4. Recommendation myelogram, postmyelogram CT scan, AP and lateral lumbar spine flexion and extension and psych eval.

On May 19, 2008 there is an office visit note by DPM. The assessment states internal ankle derangement right; foot; tendonitis, ankle instability right; tendonitis and neuritis, right foot; foot sinus tarsi syndrome, right sprain pain with associated plantar fasciitis, right foot.

On June 30, 2008 there is an office visit note by DPM. The assessment states internal ankle derangement right; sinus tarsi syndrome, right foot; tendonitis, ankle instability right; tendonitis and neuritis, right foot; foot sprain pain with associated plantar fasciitis, right foot. Plan is orthotics/brace.

On July 25, 2008 there is an imaging report by MD FACR for a lumbar myelogram under IV sedation. The findings state there is a satisfactory opacification of the lumbar thecal sac and nerve sleeve at: L3-L4 2mm external indentation is noted suggestive of a disc bulge; L4-L5 there is a 2mm external indentation compatible with disc bulge; L5-S1 there is a 1.5mm indentation compatible with mild disc bulge.

On July 25, 2008 there is a post myelogram CT scan of the lumbar spine from T12-L1 through L5-S1. The report was by MD, FACR. The impression states considerable stenosis of the central canal and lateral recesses at L3-L4 and L4-L5. Mild lateral recess narrowing at L2-L3 and L5-S1; calcification is noted in the medial aspect of the iliac arteries.

On July 25, 2008 there is an imaging report by MD, FACR for a chest x-ray. There is an addendum to a follow up examination by MD. The addendum states claimant brought the lumbar myelogram, post myelogram, lumbar CT scan. “I recommend lumbar micro decompression of the lateral nerve roots at L4-L5, right and left as well as L5-S1

On August 7, 2008 there is a follow up appointment with, MD. Recommendation to repeat the myelogram, postmyelogram CT scan as the previous facility “does not know how to do it and consequently, I have non diagnostic studies on this patient”.

On August 19, 2008 there is a follow up office visit with DPM. The assessment states tendonitis, ankle instability right; tendonitis and neuritis, right foot; foot sinus tarsi syndrome, right sprain pain with associated plantar fasciitis, right foot. Procedure was injection to the right ankle joint

On September 26, 2008 there is a follow up office visit with DPM. The assessment states tendonitis, ankle instability right; tendonitis and neuritis, right foot; foot sinus tarsi syndrome, right sprain pain with associated plantar fasciitis, right foot. Procedure was injection to the plantar aspect of the right foot.

On October 9, 2008 there is a follow up office visit with DPM. The assessment states tendonitis, ankle instability right; tendonitis and neuritis, right foot; foot sinus tarsi syndrome, right sprain pain with associated plantar fasciitis, right foot. Plan consider surgery to the plantar facia release and decompression of the first branch of the lateral plantar nerve, release of the contracted adductor haitus belly as all conservative methods of treatment have failed.

On October 22, 2008 there is an orthopedic consult by MD. Straight leg raise is negative on the right, but he has diminished sensation across the entire foot on the right. The impression states full thickness supraspinatus tear, medial meniscal tear, right knee, failed laminectomy, lumbar spine.

On December 3, 2008 there is an operative report by MD. The preoperative diagnoses were rotator cuff tear right shoulder, impingement right shoulder. Postoperative diagnosis were rotator cuff tear right shoulder, and impingement right shoulder

On December 8, 2008 there is an orthopedic report by MD. The impression states status post right shoulder arthroscopy, medical and lateral meniscal tears, status post lumbar decompression.

On January 5, 2009 there is a nerve conduction examination report by MD FAAPMR. The findings state the tibial H reflex is absent on the right. The findings states are most consistent with acute right L (?)-S1 radiculopathy.

On January 6, 2009 there is an operative report by, MD. The preoperative report diagnosis states medial meniscal tear right knee and postoperative diagnosis states medical meniscal tear right knee.

On January 14, 2009 there is a follow up orthopedic report which states status post back, shoulder and knee surgeries recovering. The plan states he still has some back pain radiating to his right leg despite his surgery. The EMG showed evidence of right S1 radiculopathy.

On February 11,2009 there is an orthopedic report by MD The physical examination states in regard to the back, he has some midline S2 space is prominent suggestive of partial lumbarization of the S1 segment of the sacrum. The impression states herniated nucleus pulposus L3-4, L4-5, L5-S1, status

post-surgery with Dr.; medical meniscal tear right knee, status post arthroscopy; rotator cuff tear, status post repair.

On February 19, 2009 there is an imaging report for an x-ray of the lumbar spine. The report was ready by MD, FACR. The report states AP and Lateral views of the lumbar spine revealed lumbar ribs at L1 bilaterally. Anterior osteophytes are seen at L4-L5. Calcification is seen in the inferior aspect on the right reproducing right leg symptoms.

On February 19, 2009 there is an imaging report for MRI of the Lumbar spine with paramagnetic contrast, intravenously, gadolinium, optimark. the conclusions states there is evidence of disc pathology at each of the L2-L3, L3-L4, L4-L5 and L5-S1 levels as described with no associated enhancing epidural fibrosis; the S1-S2 disc space is prominent suggestive of partial lumbarization of the S1 segment of the sacrum. The report is signed by MD, DABR

On April 28, 2009 there is a Peer reviewer final report which upholds the adverse determination of the BHI-2-psychoosocial screen.
The denial states the request does not meet ODG guidelines of a pre-surgical psychological evaluation and does not meet standards of care for a pre-surgical evaluation.

On May 8, 2009 there is an Imaging report signed by MD, FACR. The impression states mild disc bulge with central canal stenosis involving L3-L4 and L4-L5. There is evidence of prior left hemilaminectomy, 2 mm at L4-L5 and probably L5-S1 on the left.

On May 8, 2009 thee is an imaging report for a Lumbar Myelogram under IV Sedation. The findings state there is some attenuation of the thecal sac from L2-L3 through L4-L5 secondary to central canal stenosis. 1.5 mm extradural indentation is noted for L3-L4 and L4-L5.

On May 8, 2009 there is an imaging report signed by MD, FACR. On the AP and Lateral views of the lumbar spine it reveals five nonrib-bearing lumbar vertebral bodies, hemilaminectomy defect is noted at L4-L5 on the left side.

On May 11, 2009 there is an orthopedic report by MD. The report states that the claimant continues to have pain rated at 8/10, which is constant and radiates down both legs, but primarily to his right foot. The Physical examination states straight leg raise elicits back pain bilaterally; he has some spasms and a decreased lumbar range of motion. He has medial knee tenderness with knee range of motion from 5 degrees flexion to 120 degrees flexion. The impression states protrusion L2-3, L3-4, L4-5 and L5-S1; mechanical back pain; medial meniscal tear; rotator cuff tear.

On May 13, 2009 there is an BHI 2 enhanced interpretive report which states the claimant is experiencing localized severe pain, an unusually low level of anxious thoughts and feelings, you seem to have very few conflicts with others.

On May 21, 2009 there is a report from clinic. The claimant's pain is rated at 6/10. ROM tests performed were knees, muscles tested were knees, and grip was tested.

On May 21, 2009 there is court order by the Texas Department of Insurance Division of Workers' Compensation for an order setting Prehearing.

On May 21, 2009 there is an Orthopedic Report by MD. The physical examination states the claimant demonstrates pain with lumbar range of motion,

especially with forward flexion and lateral bending. He has posterior tenderness; straight leg raise elicits back pain bilaterally. The impression states mechanical back pain of diskogenic origin and failed laminectomy syndrome. Plan is to consider a discectomy and fusion to address the mechanical back pain. The pain generators have been identified and it is most likely L4-L5 and this fact will be confirmed in the process of performing the lumbar diskogram. The concern arises in that there may be pathology at some of the adjacent levels.

On May 26, 2009 there is a letter from MD to the Texas Department of Insurance Hearing Officer which withdrawers the request for Contested Case Hearing regarding the BHI-2 Psychosocial Screen. The letter is signed by Surgical Coordinator.

On May 29, 2009 there is an Order on Request to Dismiss Medical Dispute.

On August 7, 2009 there is a Notice of Independent Review Decision from X which upheld the previous adverse determination regarding the medical necessity of proposed low pressure diskogram at L3-4, L4-5 levels with control L2-3 and post CT.

On August 10, 2009 there is a letter from MD to the Chief Clerk of Proceedings which states: "We have reviewed the IRO decision and feel that the medical evidence contradicts the IRO physician's opinion. We are recommending a Contested Case Hearing at this time"

On August 19, 2009 there is a court document by the Texas Department of Insurance Division of Workers' Compensation which states an Order Setting Prehearing.

On February 4, 20XX there is a report from clinic. The claimant's pain is rated at 6/10. ROM tests performed were knees, muscles tested were knees, and grip was tested.

On February 4, 20XX there is an Orthopedic Report by MD. The claimant is rating his pain 8/10 with constant pain in his lower back area that radiates into his right thigh. The claimant states that he is using a back brace but his back pain seems to continuously get worse. The physical examination shows tenderness in his lower lumbar region and decreased range of motion with flexion and extension limited by pain. Straight leg raise elicits back pain only. The impression states mechanical back pain of diskogenic origin and failed laminectomy syndrome.

On May 4, 20XX there is Decision and Order from the Texas Department of Insurance Division of Workers' Compensation. The Conclusion of Law states the preponderance of the evidence is not contrary to the decision of the IRON that a low pressure diskogram at the L3-L4 and L4-L5 levels with control at L2-L3 and post CT Scan is not health care reasonably required for the compensable injury of. The Decision states the claimant is not entitled to low pressure diskogram at the L3-L4 and L4-L5 levels with control at L2-L3 and post CT scan.

On May 11, 20XX there is a report from clinic. The claimant's pain is rated at 6/10. ROM tests performed were knees, knee flexion on right is 57 degrees; muscles tested were knees, and grip was tested.

On May 11, 20XX there is an Orthopedic Report by MD. The report states that the claimant rates his pain 9/10 with constant pain in his low back area that

radiates to his right thigh. The physical examination shows tenderness in his lower lumbar region, decreased range of motion in all directions limited by pain, straight leg raise elicits back pain only. The impression is mechanical back pain of diskogenic origin and failed laminectomy syndrome. Plan is to proceed with a contested case hearing for his lumbar diskogram.

On July 6, 20XX there is a report from clinic. The claimant's pain is rated at 6/10. ROM tests performed were knees, knee flexion on right is 85 degrees; muscles tested were knees, and grip was tested.

On July 6, 20XX there is an Orthopedic Report by MD. The report states the claimant rates his pain at 6/10 with some discomfort with side to side movements, soreness and stiffness that continues to radiate into his right thigh, he also presents with right knee pain which is rated at 6/10. The physical examination shows severe tenderness in his lower lumbar region, decreased range of motion in flexion and extension limited by pain, straight leg raise elicits back pain only. The impression is mechanical back pain of diskogenic origin and failed laminectomy syndrome; medial and lateral meniscal tears, status post arthroscopy. The plan is to appeal the decision made in the contested case hearing.

September 16, 20XX there is an Orthopedic Report by which state states the claimant has participated in an at home physical therapy, on the last visit he obtained a right corticosteroid injection, which gave him approximately 50% relief. Knee pain is rated at 4/10. Low back pain is rated at 6/10 with constant pain in his low back area that occasionally radiates down into his right thigh. The physical examination shows severe tenderness in his lower lumbar region, decreased range of motion in flexion and extension limited by pain, straight leg raise elicits back pain only. The impression is mechanical back pain of diskogenic origin and failed laminectomy syndrome; medial and lateral meniscal tears, status post arthroscopy. The plan states the claimant continues to experience increased muscle spasms. We will prescribe a TENS unit.

December 16, 20XX there is an Orthopedic Report by which state states the claimant reports he obtained a corticosteroid injection approximately 5 months ago, which gave him approximately 5 months ago which gave him significant relief and he is interested in another. Knee pain is rated at 4/10. Low back pain is rated at 5/10 with constant pain in his low back area that occasionally radiates down into his right thigh. The physical examination shows severe tenderness in his lower lumbar region, decreased range of motion in flexion and extension limited by pain, straight leg raise elicits back pain only. The impression is mechanical back pain of diskogenic origin and failed laminectomy syndrome; medial and lateral meniscal tears, status post arthroscopy. The procedure states1% lidocaine and 1 ml betamethasone injection into the right suprapatellar space. The plan states the claimant continues to remain symptomatic, advised to continue using a TENS unit.

On December 16, 20XX there is a report from clinic. The claimant's pain is rated at 6/10. ROM tests performed were knees, knee flexion on right is 61 degrees; muscles tested were knees, and grip was tested.

On March 24, 20XX there is an Orthopedic Report by which states the claimant states his back pain has increased causing symptoms down his right lower extremity. He rates his low back pain at 6/10 with constant pain in his back

area, discomfort with side to side movement, soreness and stiffness. He has pain that radiates down his right lower extremity with numbness and tingling present. He also presents with right knee pain rated 4/10. The physical examination of the lumbar spine states there is tenderness in his mid to lower lumbar region with decreased range of motion with extension. He had a positive straight leg raise on the right, negative on the left. His motor strength remains weakened in his entire right lower extremity down to his extensor halluces longus. He has paresthesias along the lateral aspect down into his foot. His reflexes are 2+ in his patellae and not elicitable in his Achilles. The impression states medical and lateral meniscal tear, status post arthroscopy HNP, L4-L and L5-S1, mechanical back pain of diskogenic origin, failed laminectomy syndrome, radiculitis right lower extremity. The plan states the claimant continues to remain symptomatic; he has highly positive findings of radiculopathy on physical examination. We will recommend lumbar epidural steroid injection in conjunction with post-injection physical therapy.

On March 24, 20XX there is a report from clinic. The claimant's pain is rated at 8/10. ROM tests performed were shoulders; muscles tested were shoulders, and grip was tested.

On April 4, 20XX there is letter of denial of authorization from carrier to MD. Under the Rational: Per physician advisor: The claimant is a XX year old male diagnosed with failed laminectomy syndrome. The Official Disability Guidelines suggest that criterion for the use of epidural steroid injections includes the patient being initially unresponsive to conservative treatments. There was a lack of documentation to indicate what prior conservative therapies the patient has undergone and his functional response to therapy. Also, guidelines suggest that no more than two nerve root levels should be injected. The request as stated does not indicate at which level or level(s) the epidural steroid injection is to be performed. As such, the request for the LESI #1 for 2011 with epidurogram and fluoroscopy is not medically necessary at this time.

On April 12, 20XX there is an appeal for lumbar ESI at L4-L5 and L5-S1 (first injection for 20XX) with epidurogram and fluoroscopy. The decision is non-certified. The rationale states: this appeal for lumbar ESI at L4-L5 and L5-S1 (first injection for 20XX) with epidurogram and fluoroscopy is not medically necessary. The claimant is status post lumbar decompression and knee arthroscopy in 2008. I the latest medical report dated 3/24/11 he complained of low back pain. The recent MRI showed disc pathology at each of the L2-3,L3-4, L4-5, and L5-S1 levels. As per the post myelogram CT scan performed on 5/8/09 there is evidence of a previous hemilaminectomy at L4-5 and L5-S1. EMG NCV studies indicated L5-S1 radiculopathy. Clinical examination revealed motor deficits and paresthesias over the lower extremity down to the extensor halluces longus, positive straight leg raise on the right and an absent Achilles reflex. The records indicate that the patient was treated with Physical Therapy, lumbar epidural steroid injections and medications. However, the perceived benefit from the previous ESI was not quantified in terms of pain or activity logs, functional improvement and functional response to prior conservative care that includes Physical Therapy and pharmacotherapy. Moreover, the chronicity of this patient's low back pain and previous back surgery are considered negative factors for the success rate of this proposed injection. As such, the need for the

lumbar ESI is not established at this point and the previous non-certification is upheld.

On April 13, 20XX there is a letter of appeal denial of authorization from Carrier to MD. Under the Rational: Per physician advisor: the claimant is s/p lumbar decompression and knee arthroscopy in 2008. In the latest medical report dated 3/24/11, he complained of low back pain. The recent MRI showed disc pathology at each of the L2-3, L3-4, L4-5 & L5-S1 levels. As per the post myelogram CT scan performed on 5/8/09 there is evidence of previous hemilaminectomy at L4-5 & L5-S1. EMG NCV studies indicated L5-S1 radiculopathy. Clinical exam revealed motor deficits and paresthesias over the lower extremity down to the extensor halluces longus, positive SLR on the R & an absent Achilles reflex. The records indicate that the clmt was treated w/ PT, lumbar ESIs and medication. However the perceived benefit from the previous ESI was not quantified in terms of pain or activity logs, functional improvements & meds adjustment. Moreover, the chronicity of the clmt's low back pain & previous back injury are considered negative factors for the success rate of this procedure. Contact call 2 w/o return call.

PATIENT CLINICAL HISTORY:

On XX/XX/XXXX the claimant was injured when he fell.

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

The previous decisions are overturned for the following reasons. First, the claimant has documented radiculopathy via EMG/NCV studies, positive SLR on multiple physical examinations, an absent Achilles reflex, and documented motor deficits. Secondly, the claimant has undergone conservative treatment in the form of physical therapy and prescription medications. This claimant meets the ODG Criteria for a Lumbar ESI; therefore the previous decisions are overturned.

ODG:

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. 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)**