



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 10-27-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

O/P Lumbar Epidural Pain Block L4-L5 64483

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

American Board of Neurological Surgery

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

PATIENT CLINICAL HISTORY [SUMMARY]:

10-4-10 MD., the claimant is a gentleman, who sustained a job-related accident on xx/xx/xxxx. The patient refers he fell to the ground. He refers that he started having pain to his neck, lower back as well as on the right side of his body, shoulder, arm as well as the right hip and right leg. He did not go to the emergency room at that day. He says that about two days later he went to the emergency room at the Medical Center, where x-rays were taken. He was prescribed ibuprofen and Tylenol with codeine. The patient was initially seen by Dr. who started him on a rehabilitation program and ordered an MRI. Presently, he has been referring path to his neck. He rates it moderate and constant, radiating down to the right shoulder, right shoulder blade area as well as to right upper extremity. He refers tenderness the right shoulder. He has moderate constant pain, which increases with movements. He cannot do overhead movements and cannot reach behind his head and behind his back. In regards to low back, he is referring moderate and constant pain, which radiates to the right hip as well as on the posterior thigh/calf area He states the pain increases while sitting, standing and walking for prolonged periods of time. The patient has been off work since the accident. Physical examination: Height; 5 feet, 2 inches. Weight; 129 lbs. HEAD: Normocephalic, EENT: Normal. Examination of the cervical spine reveals paravertebral muscle spasm bilaterally with muscle spasm noted in bilateral upper trapezius area. Range of motion is decreased in flexion, extension rotation with mild discomfort noted. UPPER Extremities: Examination of the right shoulder reveals tenderness to palpation at anterolateral aspect. Range of motion is 0-100 degrees. adduction, 0-100 degrees in flexion, internal and external rotations are 30 degrees each. Neer sign is positive. Hawkins sign is also positive. Upper back: Normal. Paravertebral muscle palpation is supple. No trigger points are palpate. LOW BACK: Examination of the lumbar spine reveals paravertebral muscle spasm bilaterally. Range of motion is 0-50 degrees in forward flexion. Straight leg raise is positive to the right at 70 degrees, 80 degrees to left. Good distal sensation and circulation are present. Lower extremities. Examination of the right hip reveals mild tenderness to palpation. Range of motion is slightly decreased on rotation. Good distal sensation and circulation are present. Motor testing reveals 4/5 strength in right lower extremity as compared to left, which is 5/5. Gait is antalgic. Reflexes are decreased on the right Achilles tendon, normal at the left and normal at both patellae, normal both upper extremities. X-rays of the cervical spine taken today in five different views reveal seven cervical vertebral bodies. There is mild straightening of cervical lordosis noted. Intervertebral disc heights are preserved. No fractures, dislocations or subluxations are seen. X-rays of the lumbar spine taken today in five different views reveal five lumbar vertebral bodies. There was mild straightening of the lumbar lordosis noted. Intervertebral disc heights are preserved. No fractures, dislocations or subluxations seen. X-rays of the right shoulder taken today in two different views reveal type U acromion with positive impingement. No fractures, dislocations or subluxations seen. X-rays of the right hip taken today in three different views reveals no fractures, dislocations or subluxations. Plan: The patient is referred for EMG/NCS of the bilateral upper and lower extremities to rule out radiculopathy. He is also referred for a MRI of the right shoulder to rule out rotator cuff tear. He is prescribed medication in the form of

Celebrex, Ultracet and Soma. Return on October 19, for a follow-up visit. Remain off work. The patient has been educated regarding his pathology.

11-17-10 MRI of the lumbar spine shows at L4-L5 there is a 1-2 mm central bulge of the disc with slight to marginal impression on dural. In addition, there is a discrete 3-3.5 mm left posterior disc protrusion to possible very small herniation into the left neuroforamina with contiguity with but no overt impression on the left L4 nerve root. The disc is slightly dehydrated and of borderline height.

12-29-10 MD., performed a Peer Review. The mechanism of injury is a fall from a cotton loader onto the ground. Based on the medical records provided, the compensable injury and diagnosis is a soft tissue strain of the para-vertebral musculature of the lumbar and cervical region of the spine, right shoulder strain, and right hip contusion. There is no evidence of any aggravation of these pre-existing conditions. There is no evidence of enhancement, acceleration, or worsening of an underlying condition or new damage or harm to the physical structure of the body. The claimant's current symptoms and signs are not related to the diagnosis listed in #2. The claimant should not have chronic cervical and lumbar pain as well as hip and shoulder pain 4 months after the fall and injuries described. The claimant's current symptoms are unrelated and due to underlying, pre-existing conditions of degenerative disc disease and shoulder impingement. Degenerative disc disease and shoulder impingement are age related conditions due to ordinary disease of life. Furthermore, it is questioned how much pain and disability this claimant truly has due to his lack of full effort and symptom magnification on the recent functional capacity examination. The claimant's current symptoms are unrelated to the original injury. Therefore, the Official Disability Guidelines would support the claimant could be directed to take over the counter medications on an as needed basis if there is no contraindication to this and if the claimant understands the possible side effects of these medications. The injured employee should also be directed to participate in a home-based, self-directed exercise program emphasizing overall conditioning and fitness. That is all that is indicated to address the sequelae of the compensable event. The claimant requires no additional referral to specialists, invasive testing, durable medical equipment, formal physical therapy, chiropractic care, physician of visits, surgery, work hardening or conditioning, chronic pain management program, individual psychological counseling, prescriptive medications or injections.

1-12-11 Unknown provider - notes the claimant is provided with Vicodin and Flexeril.

1-27-11 MD., the claimant states that he had a work related injury on xx/xx/xx, when he was on top of the module builder when the compartment door was opened and he fell from approximately 14 feet, landing on his feet, right, side of the body and ended up on his back. The patient is complaining of pain on his neck and low back. The patient describes the pain on his neck as being constant, sharp, radiating down to his right shoulder and arm, with no provoking factors, 10/10 on the pain scale, with tingling of the right. The patient describes the pain on his low back as being constant, sharp, radiating from his right hip down to his right leg, provoked when bending, walking,

sitting, and getting up from the sitting position, 10/10 on the pain scale. On exam, power is decreased on the right arm, with decreased feeling art C5-C3 on the right side, with spasm to the lumbar spine, with tenderness to the cervical spine, and straight leg raise is 40 degrees on the right and 80 degrees on the left. Plan: Tramadol, Naproxen
Diagnosis: Cervicalgia and lumbago.

Follow up with Dr. on 3-01-11 notes the claimant reports neck and low back pain. Since the claimant is still very symptomatic, he recommended an epidural block and facet block L4-L5 and S1. He should continue on Tramadol and Naproxen.

3-9-11 MD., the claimant presented for right shoulder pain. He is pending a right shoulder injection.

3-12-11 MD., performed a Designated Doctor Evaluation. He certified the claimant had reached MMI and awarded the claimant 5% impairment rating for the low back under DE II, 5% for the cervical spine and for the right shoulder based on range of motion loss, the claimant is given 11% WP for a total of 20% WP.

3-29-11 Follow up with Dr. notes the claimant still complains of neck and low back pain. He reports medications does not work as well. The claimant is still very symptomatic. He recommended continue Tramadol and Naproxen.

4-18-11 IRO notes that Insurance carrier response to the disputed services dated March 30, 2010 notes a lumbar radiculopathy or acute facet involvement is not substantiated by clinical examination findings or imaging studies. There is no documentation of physical therapy. Treatment has been medications only. ODG does not support ESIs without concurrent confirmation of radicular signs and symptoms along with a positive imaging study, which have not been documented. ODG also does not recommended facet Injections to be performed at the same time as an epidural injection.

Follow up wit Dr. on 4-19-11 notes the claimant presents with low back pain radiating to the legs with spasms and weakness of the legs as well. He also reports neck pain. On exam, he still has severe pain in his back with weakness at the right leg, with stiffness to the back. Plan: He is still very symptomatic. Medications: Tramadol and Naproxen.

5-5-11 MD., the claimant is seen for his right shoulder. The evaluator reported the claimant needed to get a new treating doctor as he was closing his practice.

5-25-11 MD., performed a Required Medical Evaluation. He certified the claimant had reached MMI on 3-12-11 and awarded the claimant 4% impairment rating based on range of motion loss of the shoulder. He rated the lumbar spine under DRE I for 0% and for the cervical spine.

Follow up with Dr. on 5-26-11 notes the claimant complains of neck pain that radiates to the right shoulder and low back pain radiates to the right hip and lateral thigh that does

not improve with medications. Since the claimant is still symptomatic he recommended Tramadol and Naproxen.

6-16-11 Follow up with Dr. notes the claimant reports medications are not helping. He continues with constant pain on the hips and legs with legs weakness. On exam, he has pain on the right side of the neck, very tender at the cervical spine. Limited range of motion at the neck. Limited back movement. No other deficits. The claimant was continued with his current medications.

7-5-11 Follow up with Dr. notes the claimant continues with low back pain radiating to the legs with burning sensation, numbness and tingling in the legs. On exam, he has tenderness to the cervical spine, limited neck movement, motor functions are normal. Sensation is normal. Reflexes are normal with spasms at the lumbar spine, limited back movement in all directions. The evaluator recommended the claimant continue with current medications.

8-16-11 Follow up with Dr. notes the claimant is still complaining of low back pain radiating to both legs with numbness, tingling and burning sensation of the legs. The patient states that the Tylenol #3 is affecting his stomach but he still takes it to alleviate his pain. On exam, neurologically the patient is doing well, except the pain is sharper. Plan: Since the patient is still very symptomatic. He recommended that he should have an epidural pain block L4-L5 at Brownsville Doctors Hospital. Meanwhile he should continue on his current treatment Tylenol #3 q6h PRN and Flexeril 10mgs BID. He will see him in three weeks for a follow up.

9-1-11 UR performed by DO., it was her opinion that as per medical report dated 8-16-11, the patient complains of low back pain radiating to both legs with numbness, tingling and burning sensation of the legs. Physical examination showed he was neurologically intact. Exam of the back dated 3-12-11 documented there is point tenderness at the gluteus medius on the right. His back ROM appears to be decreased approximately 50 percent in flexion with minimal to moderate pain on extension without loss of ROM. His sensation is intact to pinprick at all dermatomal level. His DTR's are 2+ Achilles tendon bilaterally with negative Hoffman's. Upon review of the report, there is no clear documentation of conservative treatment. There are no PT progress notes to show the patients clinical and functional response. Optimized pharmacotherapeutic utilization in conjunction with VAS scoring and rehabilitative support is not evident in the report without documented failure of conservative management and radiculopathy on exam with findings in the dermatome myotome of request. With these, the need for the request is not substantiated at this time. Determination: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request for lumbar epidural pain block L4-L5 (no Codes) is non-certified.

9-6-11 MD., performed a Designated Doctor Evaluation to address the extent of injury. Of note, the examinee exhibits symptom magnification and positive Waddell signs when distracted. The examinee has pain on back and neck when questioned. He referred the

examinee for the following diagnostic testing for completion of his examination regarding MMI assessment and/or whole person impairment rating assignment As per Rule 130.6 (g) a Designated Doctor may perform or refer an injured employee to other health care providers when deemed necessary for MMI and/or Impairment Rating determination. Any additional testing required for the evaluation process is not subject to preauthorization in accordance with the Texas Labor Code 413.014, he attached the diagnostic testing results to this report for your review and will submit the results to all concerned parties with regards to this examinee. He referred the examinee for an MRI of the right shoulder performed on 09/22/2011 at Harlingen Medical Center which revealed: Mild degenerative in the AC joint. SLAP tear of the glenoid labrum with para labral cyst extending medially in spinoglenoid notch measuring 16 x 18 mm. Minimal fluid in the glenohumeral joint. Extent of injury: The examinee sustained a work related injury on 08/14/2010 while employed as a Laborer for it is my opinion, based on reasonable medical probability, the accident/incident giving rise to the compensable injury(s) is a cause of the following area(s); Lumbar strain and Cervical strain. His examination does not demonstrate evidence of radiculopathies. There was no loss of reflexes, sensory loss, or muscle atrophy. His right hip, right leg, right knee, and right ankle contusion has resolved. No findings on physical examination. He complains of right shoulder pain. The MRI performed on right shoulder dated 09/22/2011 showed a SLAP type of tear of the glenoid labium. This is a new finding. The original MRI dated 11/12/2010 at McAllen Medical center showed an intact glenoid labrum per Dr. reading. The only consistent finding is degenerative hypertrophic changes (disease of life) as both MRIs and a type II acromion process. Therefore, the extent of injury of right shoulder is confusion injury.

Follow up with Dr. on 9-8-11 notes the claimant reports he is the same without any change. Since he is very symptomatic, he will continue to recommend an epidural block at L4-L5.

9-21-11 MD., performed a UR. It was his opinion that Records indicate that there was an adverse determination of a previous review. In acknowledgement of the previous non-certification due to lack of documentation of conservative treatment, PT progress notes to show the patient's clinical and functional response, optimized pharmacotherapeutic utilization in conjunction with VAS scoring and rehabilitative support, and radiculopathy on exam with findings in the dermatome/myotome of request, there is now documentation of conservative treatment including PT. In addition, the patient presented with low back pain. Imaging findings include a 11/17/10 lumbar MRI report identifying a 1-2mm central bulge of the L4-5 disc with slight to marginal impression on dura, there is a discrete 3-3.5mm left posterior disc protrusion to possible very small herniation into the left neuroforamina with contiguity with but no over impression on the left L4 nerve root. However, there remains no clear documentation of radiculopathy, pain, numbness, and/or paresthesias in a dermatomal distribution; an imaging study documenting correlating concordant nerve root pathology; and associated clinical findings such as loss of relevant reflexes, muscle weakness and/or atrophy of appropriate muscle groups, loss of sensation in the corresponding dermatomal and patient initially unresponsive to additional conservative treatment

(exercises, NSAIDs, and muscle relaxants). Therefore, the medical necessity of the request has not been established. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this appeal for a lumbar epidural pain block to L4-L5 (no codes) is non-certified.

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

MEDICAL RECORDS REFLECT A CLAIMANT WITH AN INJURY FROM 2010. THE CLAIMANT HAD AN MRI WHICH SHOWED A BULGE AT L4-L5 BUT NO IMPINGEMENT AT THE L4 NERVE ROOT. THERE IS NO CLEAR DOCUMENTATION OF RADICULOPATHY. DOCUMENTATION NOTES THE CLAIMANT IS NEUROLOGICALLY INTACT. THE CLAIMANT WAS SEEN BY A DESIGNATED DOCTOR AND ALSO HAD A REQUIRED MEDICAL EVALUATION, NONE OF WHICH DOCUMENTED ANY OBJECTIVE EVIDENCE OF RADICULOPATHY. ON 8-16-11, HIS TREATING DOCTOR, DR. REPORTED, NEUROLOGICALLY, THE PATIENT IS DOING WELL EXCEPT THE PAIN IS SHARPER. THERE IS NO INDICATION THAT THE CLAIMANT HAS RADICULOPATHY, AS REQUIRED BY CURRENT TREATMENT GUIDELINES FOR THE PERFORMANCE OF A LUMBAR BLOCK. THEREFORE, THE REQUEST FOR AN O/P LUMBAR EPIDURAL PAIN BLOCK L4-L5 64483 IS NOT REASONABLE OR MEDICALLY INDICATED.

ODG-TWC, last update 10-21-11 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](#)) A recent RCT of 29 patients divided into three groups addressed the use of ESIs for treatment of spinal stenosis. A control group with no treatment was compared to a group receiving passive physical therapy for two weeks and another receiving an interlaminar ESI at the stenotic level. At two weeks the group that received the ESI had significantly better pain relief than the other two groups. When the three groups were compared there was no

statistical difference except in pain intensity and Roland Morris Disability Index and this was at two weeks only. The authors stated that improvement only appeared to be in the early phase of treatment. ([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. ([Savegh, 2009](#)) ESIs are more often successful in patients without significant compression of the nerve root and, therefore, in whom an inflammatory basis for radicular pain is most likely. In such patients, a success rate of 75% renders ESI an attractive temporary alternative to surgery, but in patients with significant compression of the nerve root, the likelihood of benefiting from ESI is low (26%). This success rate may be no more than that of a placebo effect, and surgery may be a more appropriate consideration. ([Ghahreman, 2011](#))

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)