



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 12-19-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lumbar epidural steroid injection (ESI) with fluoroscopy

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

American Board of Orthopedic 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

- 5-24-99 CT scan of the lumbar spine.
- office visits on 6-3-99, 6-28-99, 7-8-99, 7-12-99, 8-2-99, 11-5-99, 12-13-99, 1-24-00, 3-6-00, 4-17-00, 7-10-00, 12-21-00, 3-26-01, 6-28-01, 8-27-01, 9-24-01, 10-25-01, 12-13-01 3-28-02, 3-28-11. 6-2-11. 6-23-11. 9-22-11 and 10-31-11.
- 7-27-99 CT scan post myelogram.
- 10-22-99 Surgery performed by.
- 6-20-00 MRI of the lumbar spine.
- 9-19-00 Surgery performed by.
- 10-12-00 X-rays of the lumbar spine.
- 12-21-00 X-rays of the lumbar spine.
- 6-28-01 X-rays of the lumbar spine.
- 8-28-01 X-rays of the lumbar spine.
- 9-24-01 X-rays of the lumbar spine.
- 3-15-02 CT scan of the lumbar spine.
- 6-27-02 Procedure performed by.
- 3-1-11 Procedure performed by.
- 6-13-11 CT scan of the thoracic spine shows no acute abnormality.
- 6-13-11 CT scan of the lumbar spine.
- 11-9-11, performed a UR.
- 11-22-11, performed a UR.

PATIENT CLINICAL HISTORY [SUMMARY]:

5-24-99 CT scan of the lumbar spine shows posterior disc protrusions at L4-L5 and L5-S1 with evidence of past right laminectomy at L5.

6-3-99, the claimant was injured on xx/xx/xx while he was lifting. He had the immediate onset of low back pain which got worse overnight and the next day was quite severe, keeping him from returning to work. His main problem has been severe low back pain but he has also had bilateral hip and leg pain, worse on the right, along with some numbness and dysesthesias, in the legs. The pain is aggravated by walking, standing and activities. He has had no lower abdominal pain or sphincter abnormalities. He has not been able to return to work. Your treatments have given him some benefit. However, because of persistent problems, he underwent a lumbar CT scan on 24 May showing central disk protrusions at L4-5 and L5/S1, X-rays show what appears to be a previous right L5/S1 laminectomy and he did have lumbar surgery for right leg pain in 1985. He was not able to return to work for about three years after the surgery but since he has been back at work, he has done reasonably well except for some episodes of low back pain with aching in the hips and legs until this present injury about three weeks ago. He has been taking Ibuprofen with limited benefit. X-rays show some mild degenerative changes. He takes no routine medications. He is allergic to Darvocet, Lortab and Codeine. He does not use alcohol or tobacco. He has been treated for sinusitis and also had a testicular tumor removal two years ago. He has generally been in good health. There is no familial disease tendency. On examination, he is 6'2" in height and weighs 210 pounds. He has a well healed lumbar incision. There is severe paralumbar muscular tightness with complete loss of lumbar lordosis. He walks with a flexed posture at the low back. There is limited mobility of the low back in all directions. There is a little tenderness over the right sciatic outlet. He is able to tale stand and heel stand and strength appears to be normal in the lower extremities. There is no pain with hip rotation. Straight leg raising is positive on the right at 45° and positive on the left at 60°. Deep tendon reflexes are 2+ in the knees and 1+ in the ankles. There is no Babinski response. He has no muscular atrophy or fasciculations. Pulses are intact in both feet. He has a severe lumbosacral strain with L4-5 and L5/S1 disk disease and possible radiculopathies. Treatment options were discussed with him. He is placed on Motrin 800 mg bid or t.i.d He is to continue to limit his activities. He doubted he can return to work within the next ten to fourteen days. He should continue with your treatments. He will be seen in follow-up in about ten days.

6-28-99, the claimant is quite symptomatic. He still has low back pain and bilateral leg pain, mostly on the right. It has been six weeks since his injury. The evaluator recommended an MRI. He is unable to work.

6-28-99 MRI of the lumbar spine shows previous partial laminectomies on the right side at L4-L5 and L5-S1. There is soft tissue material extending posteriorly from the disc at L4-L5 and projecting cephalad up behind the posterior inferior body of L-4. Most of this enhances, but there does appear to be some disc material within this enhancing scar. He was uncertain as to the clinical significance of this however. There does not appear to be marked compromise of the thecal sac or definite nerve root displacement. At L5-S1, there is a mild right paracentral disc protrusion but it does not appear to be touching the thecal sac or the nerve roots in the area of the protrusion. The other discs in the lumbar spine appear to be normal in signal without evidence of herniation.

7-12-99, the claimant was allowed to return to work but did not do well. He had markedly increased pain in the low back and both legs, particularly on the right side. He is awaiting lumbar myelogram. The claimant was taken off work. He was given Ibuprofen and Talwin.

7-27-99 CT scan post myelogram shows a very small central right paracentral disc protrusion at the L4-L5 level.

8-2-99, the claimant had a post myelogram CT scan showing a central and right L4-L5 disc herniation. He also has bulging of the disc on the right at L5-S1. He has severe radiating right leg pain and a right antalgic gait with a very positive SLR on the right and mild weakness of right foot and great toe dorsiflexion. He needs a right L4-L5 microdiscectomy and probably exploration of the right at L5-S1.

10-22-99 Surgery performed by: Right L4-L5 laminectomy with excision of recurrent herniated disc. Right L5-S1 decompression, recurrent.

11-5-99, the claimant is two week after right L4-L5 and L5-S1 laminectomies for disc for treatment of severe radiculopathies. He had complete relief of his right leg pain. He is increasing his activities.

4-17-00, the claimant is six months post microdiscectomy. He has some residual low back and a little aching in the right leg but does not have radicular pain. He reports he is in a work hardening program. He takes occasional Celebrex.

6-12-00, the claimant has some chronic aching pain in the low back and pain in both hips and legs, mainly on the right side. He takes occasional Celebrex. He is unable to take mos analgesics. He recommended a lumbar MRI.

6-20-00 MRI of the lumbar spine shows the claimant has had previous laminectomy procedures on the right side at L4-5 and L5- S1 levels. L3-4 disc space: The disc, dural sac, epidural fat, neuroforamina, and facet joints are maintained. L4-5 disc space: Postoperative changes secondary to right laminectomy procedure noted at this level. Note is made of contrast enhancing scar at the operative site and extending along the right side of the dural sac and anterior to the right side of the dural sac to the level of the midline anterior to the dural sac. This scar does demonstrate contrast enhancement. There is evidence of desiccation of the disc with mild narrowing of the disc space. There is no evidence of herniation or bulging of the disc at this level. The neuroforaminal and facet joints are maintained. L5-S1 disc space: Postoperative changes secondary to right laminectomy procedure noted at this level. Contrast enhancing scar is noted at the operative site. The dural sac is maintained, however. There is desiccation of the disc at this level, however, the disc is maintained with no evidence of herniation or bulging of the disc at this level. The neuroforamina and facet joints are maintained. Sagittal images demonstrate no other abnormality

8-21-00, the claimant is having severe mechanical pain in the low back in the right leg. He walks in a flexed posterior at the low back and has limited mobility. The Neurontin has not helped. He is not able to take most medications. He takes Talwin occasionally. The evaluator reported that due to his constant leg pain, a posterior approach would be advisable and that will include interbody cages and pedicle screws and posterolateral fusion from L4 to sacrum.

9-18-00, the claimant was originally referred by. He was injured in xx/xxxx while at work. He had the onset of low back pain and right leg radiating pain and underwent right L4-5 and L5-S1 laminectomies with excision of recurrent herniated disc at L4-5 and at L5-S1. Those procedures were done in October 1999. He had had a previous surgery 15 years ago with right L4-5 and L5, Si laminectomies. He initially did well after his surgery a year ago and he was followed in the office. He initially had complete relief of his right leg pain. He received physical therapy and medications and gradually increased his activities. He gradually improved. By April he was having some increasing mechanical pain in the low back. He had all forms of conservative measures. He then began to complain of aching pain in the hips and legs mainly on the right side. He had increasingly severe mechanical pain in the low back with aching pain in both legs, particularly on the right side. MR scan showed some changes at L4-5 and L5-S1 with no evidence of large recurrent disc. He was started on Neurontin. He did not want a steroid injection done. He is taking Celebrex. When he was seen in August, he was having increasingly severe mechanical pain in the low back. He had aching in the right leg. He walked with a flexed posture at the low back. He was unable to take most medications. It was felt that he needed stabilization because of his persistent pain and this could be done anteriorly or posteriorly. He will have a posterior approach with interbody cages where appropriate with pedicle screws and a posterolateral fusion from L4 to the sacrum. He and his family fully understand the risks and possible complications of the procedure including death, vegetative state, increased pain, nerve damage, vascular damage, paraplegia, hemorrhage, infection, cerebrospinal fluid, fistula, loss of bladder, bowel and sexual function, need for further surgery, pseudarthrosis, instrumentation failure, cage extrusion, etc. On exam he has a well healed lumbar incision. He has paralumbar muscular tightness with loss of lumbar lordosis. He walks with a slightly flexed posture at the low back. There is decreased mobility of the low back. There is tenderness over the right sciatic outlet. He has a little difficulty toe standing and heel standing on the right side. He has little decreased sensation in the right L5 and S1 dermatomes. No pain with hip rotation. Good pedal pulses. No muscular atrophy or fasciculations. Straight leg raising positive right at 45 degrees, positive left at 60 degrees, deep tendon reflexes 2+ in the knees, 1+ left ankle,, trace right ankle. There is no Babinski response. He has no muscular atrophy or fasciculations. Impression: Status postoperative right L4-5 and L5, S1 laminectomy for disc. Severe chronic mechanical low back disorder. L4-5 and L5, S1 discopathies. Residual radiculopathies.

9-19-00 Surgery performed by: decompressive L4 through S1 laminectomy, recurrent. Bilateral L4-L5 and S1 root decompression, excision of herniated disc, interbody fusion, carbon fiber cage implants, pedicle screws and rods with crosslink.

10-12-00 Follow up with note she is three weeks post his surgery. He can begin physical therapy and chiropractic therapy at this time. He wears his TLSO.

10-12-00 X-rays of the lumbar spine shows stable post surgical changes.

12-21-00 X-rays of the lumbar spine shows status post fusion L4-S1.

6-28-01 X-rays of the lumbar spine shows stable post surgical changes.

Follow up, on 8-27-01 notes the claimant is now 11 months post surgery. Strength and sensations are normal in the lower extremities. He walks reasonably well. He takes Ultram and Flexeril and Neurontin because of some burning dysesthesias in the legs.

8-28-01 X-rays of the lumbar spine shows stable post surgical changes.

9-24-01 X-rays of the lumbar spine shows postop changes due to previous posterior decompression procedure and bilateral posterior fusion procedure noted at L4-L5 and L5-S1 disc spaces. Bilateral pedicle screws are present at L4, L5, S1 and transfix posterior plates. Orthopedic screws are seated as visualized on the lateral projection. Interdisc spacer material is present at L4-L5 and L5-S1 and this interdisc spacer material does appear seated at both levels. With the flexion and extension, the vertebral bodies are maintained in anatomic alignment and position. The remaining disc spaces are maintained. Vertebral body heights are maintained.

Follow up with on 2-25-02 notes the claimant has more aching pain in the low back and in both legs. The evaluator recommended lumbar myelogram and post CT scan.

3-15-02 CT scan of the lumbar spine post contrast showed at L4-L5 there has been a bilateral laminectomy and discectomy. At L5-S1 the laminectomy adequately unroofs the canal. Cannot rule out foraminal stenosis related to granulation tissue and scarring.

6-27-02 Procedure performed by: spinal cord stimulator placement.

3-1-11 Procedure performed by: Removal of left lower quadrant spinal cord stimulator battery. Removal and replacement of lower thoracic spinal cord stimulator. Removal and replacement of spinal cord stimulator leads. Octad lead lower thoracic, right. Placement of left gluteal spinal cord stimulator battery generator.

3-28-11, the claimant is almost a month after removal, revision, and replacement of his spinal cord stimulator leads and battery. All of his incisions are well-healed and he removed the sutures. He is doing very well. He is getting good benefit from the stimulator. He takes an occasional Hydrocodone 7.5 mg and Ultram. He also takes Neurontin 400 mg. t.i.d and Ambien 10 mg h.s. PRN. He is neurologically stable. He is increasing his activities. He has follow-up visit in two months.

6-2-11, the claimant is three months after removal, revision, and replacement of his spinal cord stimulator, leads, and generator/battery. More recently, he has been having a feeling of numbness and weakness in the lower extremities, particularly the left lower extremity. He is able to ambulate without support but has a left limp. Re is having some lumbar pain. The stimulator does help. He has some mild weakness in the lower extremities, and needs a CT scan of the lumbar and thoracic spines to farther investigate this new finding. He has had no subsequent injury. He takes Hydrocodone 7.5 mg, Neurontin 600 mg t.i.d., and Ambien. He will be followed.

6-13-11 CT scan of the thoracic spine shows no acute abnormality.

6-13-11 CT scan of the lumbar spine shows postop changes at L4-5. No hardware complications are identified. No mass or abnormal enhancement is identified. No fracture, subluxation or focal bone lesion is present. Mild spondylitic changes of the facet joints are present. There paravertebral soft tissue interfaces also are normal.

6-23-11, the claimant had thoracic and lumbar CT scans, not showing any stenosis, herniated disk, or cord or root compression. The stimulator leads are in proper position. He ambulates without support. He continues to take occasional Hydrocodone 7.5 mg, Neurontin, and Ambien. He can continue with your treatments. He has a return appointment in three months.

9-22-11, the claimant is about the same. He has a little bit more pain in the right para lumbosacral region, particularly shen he is more active. However, the pain is not radicular. The evaluator could not find any differences on his spinal or neurological examination. No spinal diagnostic studies will be done. He is fairly active. He takes Hydrocodone 7.5 mg, Neurontin 600 mg, Ambien prn.

10-31-11 Follow up with notes the claimant left leg pain is getting worse to the point of nearly falling. Recommendations: Epidural steroid injection.

11-9-11, performed a UR. He noted this claimant was Injured in 1999 due to lifting. Request is for repeat ESI Last office visit is from 10/31. %states claimant had ESI on 10/22/11. Claimant is about the same. There is more active pain but is not radicular. CT showed no stenosis, herniated disc corridor root compression. There's mild weakness in the bilateral lower extremities. No dermatomal or myotomal exam is seen. No results from previous injection are seen.

11-22-11, performed a UR. He noted that the documentation reviewed Indicates that the claimant was injured on 5/1811999 when the claimant strained his low back due to a lifting injury. The claimant has previously undergone decompressive laminectomy with bilateral L4-51 interbody fusion, cage implants, posterolateral fusion and placement of screw and rods with autograft. The current documentation is extremely limited; It does not contain a comprehensive evaluation of the claimant's symptomatology nor a complete physical/neurological examination to determine the claimant's present clinical

status. The claimant clearly has failed back surgery syndrome. The claimant has undergone an Implantation of a spinal cord stimulator (SCS) and removal, ODG require that there must be documentation of radiculopathy in physical examination and correlation on imaging studies. There is no documentation of true radicular symptoms. The claimant has also undergone a previous EST; there amount of relief is not documented. ODG also require that there must be at least fifty (50) percent (%) pain relief. Therefore, I agree with the previous reviewing physician and uphold the denial

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

Claimant has been subjected to multiple surgical procedures which have resulted in failed lumbar surgery syndrome.

The request for a lumbar epidural injection is not support by the medical records provided. There are subjective complaints with an absence of objective findings of radiculopathy. Furthermore, this injection is only a temporary benefit at best. Therefore, the request for outpatient lumbar epidural steroid injection (ESI) with fluoroscopy is not reasonable or medically necessary.

ODG-TWC, last update 12-13-11 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) Two recent RCTs of caudal injections had different conclusions. This study concluded that caudal injections demonstrated 50% pain relief in 70% of the patients, but required an average of 3-4 procedures per year. (Manchikanti, 2011) This higher quality study concluded that caudal injections are not recommended for chronic lumbar radiculopathy. (Iversen, 2011)

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) 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)**