



Medical Review Institute of America, Inc.  
America's External Review Network

DATE OF REVIEW: September 4, 2007

IRO Case #:

**Description of the services in dispute:**

Medical necessity of epidural steroid injection (ESI).

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

The physician providing this review is board certified in Anesthesiology and is a doctor of Osteopathy. The reviewer is currently an attending physician at a major medical center providing anesthesia and pain management services. The reviewer has participated in undergraduate and graduate research. The reviewer has been in active practice since 1988.

**Review Outcome:**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld.

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.

The ESI is not medically necessity.

**Information provided to the IRO for review:**

**Records from the state:**

Notice of case assignment 9/9/07 1 page

Notice of URA assignment 8/20/07 1 page

IRO request 8/16/07 7 pages  
Claim form 12/9/06 1 page  
Memo dated 1/8/07 1 page  
Fax coversheet to precert 7/9/07 1 page  
Notification of determination 7/12/07 3 pages  
Fax Coversheet to precert 7/25/07 1 page  
Review determination 3 pages  
Records from the provider:  
After hours progress note 7/28/95 1 page  
Employers first report of injury 8/2/05 1 page  
Prescription for PT 8/1/95 1 page  
PT progress notes 8/1/95–8/7/95 1 page  
PT consult notes 8/1/95 3 pages  
PT consult notes 8/7/05 2 pages  
PT progress notes 8/7/95–8/15/95 2 pages  
Prescription for continued PT 1 page  
PT consult notes 8/14/95 2 pages  
PT progress notes 8/14/95–8/23/95 2 pages  
PT consult notes 8/28/95 2 pages  
PT consult notes 8/29/95 2 pages  
Colon and rectal clinic notes 8/31/95 1 page  
PT consult notes 8/31/95 1 page  
PT consult notes 8/6/95 2 pages  
PT progress notes 8/29/95–9/7/95 2 pages  
Orthopaedic note 9/8/95 1 page  
Case review note undated 1 page  
Medical report 9/12/95 1 page  
PT progress notes 9/13/95–9/12/95 2 pages  
Prescription for continued PT 9/22/95 1 page  
Lumbar ROM undated 2 pages  
PT consult notes 9/21/95 2 pages  
PT progress notes 9/21/98–10/4/95 3 pages  
PT consult notes 10/4/95 2 pages  
Report of medical evaluation 10/6/95 1 page  
MRI report 10/14/95 2 pages  
Medical report 10/17/95 2 pages  
Initial medical report 11/8/95 2 pages  
Subsequent medical report 12/11/95 2 pages  
Operative report 3/4/96 3 pages

Rehab initial evaluation 4/10/96 2 pages  
Rehab progress note 4/26/96, 5/8/96, 4 pages  
Letter from MD 7/17/96 3 pages  
Report of medical evaluation 7/17/96 1 page  
Consult note 10/14/98 2 pages  
Discogram report 2/4/99 2 pages  
Operative report 4/27/99 2 pages  
Office note 8/23/99 1 page  
Progress note 1/5/00 1 page  
Office note 2/16/00 1 page  
Office note 5/17/00 1 page  
MRI report 6/7/00 2 pages  
Office note 7/17/00 1 page  
Progress notes 8/20/00–1/8/01 3 pages  
Office note 8/29/01 1 page  
Work status report 4/30/02 1 page  
Office note 4/30/02 1 page  
EMG/NCV 6/4/02 2 pages  
Letter from Dr. 6/4/02 1 page  
Work status report 7/15/02 1 page  
Office note 7/15/02 1 page  
Letter from Dr. 9/4/07 3 pages  
Case review denial 8/26/02 3 pages  
notes 9/19/02–10/18/02 14 pages  
Office note 10/21/02 1 page  
Pain management initial eval 11/19/02 2 pages  
Operative report 12/06/02 3 pages  
Operative report 2/20/03 3 pages  
Pain management progress note 4/1/03 1 page  
Prescription dated 5/23/03 1 page  
IME 7/3/03 1 page  
Office notes undated 1 page  
Pain management progress notes 8/13/03 1 page  
Summary sheet undated 1 page  
Patients rights and responsibilities 10/02/03 1 page  
H&P 10/2/03 1 page  
Consent for operation 10/2/03 1 page  
Operative report 10/2/03 1 page  
Surgical checklist 10/2/03 1 page

Sedation procedure record 10/2/03 1 page  
Recovery room record 10/2/03 1 page  
Post procedure notes 10/2/03 1 page  
Admission assessment 10/2/03 4 pages  
Patient education record 10/2/03 2 pages  
Pre-op orders 10/2/03 1 page  
Post op orders 10/2/03 1 page  
Patient care record 10/2/03 1 page  
Post op procedure record 10/3/03 2 pages  
Discharge instructions undated 1 page  
Prescription for PT 11/4/03 1 page  
Initial evaluation 11/10/03, 11/12/03 8 pages  
Pain management progress note 2/3/04 1 page  
MRI report 2/11/04 1 page  
Letter from Dr. 3/1/04 1 page  
Pain management progress note 5/4/04 1 page  
History and physical exam 6/30/04 1 page  
Pain management progress note 8/10/04 1 page  
CT scan report 8/11/04 2 pages  
EMG/NCV study 9/14/04 2 pages  
CT scan report 9/15/04 4 pages  
Independent review 11/22/04 3 pages  
Pain management progress note 1/19/05 1 page  
MRloA review 5/5/05 4 pages  
Pain management progress note 8/23/05 1 page  
Pain management progress note 10/5/05 1 page  
notes 10/18/05–12/05/05 16 pages  
Pain management progress notes 2/7/06 1 page  
MRI report 10/2/06, 10/24/06 4 pages  
History and physical 12/19/06 8 pages  
Note from Dr. 4/17/07 1 page  
Pain management progress note 5/16/07 1 page  
Patient insurance information 5/31/07 1 page  
History and physical 5/31/07 1 page  
Lab report 5/31/07 3 pages  
Disclosure and consent 5/31/07 6 pages  
Patient monitoring form 5/30/07 2 pages  
Operative note 5/31/07 2 pages  
Sedation assessment 5/31/07 1 page

Post procedure note 5/31/07 2 pages  
Pre-op orders 5/31/07 1 page  
Medication record 5/31/07 1 page  
Post op orders 5/31/07 1 page  
Physician orders 5/31/07 1 page  
Patient consent for vaccine 5/31/07 1 page  
Outpatient surgery admit sheet 5/31/07 5 pages  
Pain management flow sheet 5/31/07 4 pages  
Fall risk assessment 5/31/07 1 page  
Dismissal instructions 5/31/07 1 page  
Pain management progress note 7/3/07 1 page  
Letter from Dr. 7/25/07 1 page  
Disclosure and consent 5/31/07 3 pages

**Patient clinical history [summary]:**

The patient is a female with a date of injury in xxxx. The patient had lumbar surgery in 1999. An MRI of 6/00 showed epidural fibrosis. An MRI of 10/06 showed a bulge at L4/5. The patient had 2 epidural steroid injections (ESIs) with Dr. in 12/02 and 2/03. His own note of 4/03 states they had minimal effect. He is now requesting them again. The patient has negative straight leg raise (SLR) noted multiple times. Despite all this, she had an ESI in 5/07 with only partial and temporary relief noted.

**Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision:**

These injections are denied for multiple reasons. First, The patient has an injury that is xx years old. Second, she had prior lumbar surgery with documented scar tissue. Both of these findings minimize the efficacy of an ESI. Third she had these done in 2002 and 2003 with no relief by this same doctor; these were recently repeated with no sustained relief again. Fourth, she has negative neuro exam and an MRI that shows no HNP or nerve root impingement by disc. For all these reasons, the injection is denied.

**A description and the source of the screening criteria or other clinical basis used to make the decision:**

ASIPP Guidelines as reprinted in Pain Physician 2/07. ACOEM pg 300,309.

ODG: 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. (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) 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)

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) (Boswell, 2007) Also see Epidural steroid injections, “series of three” and Epidural steroid injections, diagnostic. ESIs may be helpful with radicular symptoms not responsive to 2 to 6 weeks of conservative therapy. (Kinkade, 2007) 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.

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and 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) 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 two injections should be performed. A second block is not recommended if there is inadequate response to the first block. 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. To be considered successful after this initial use of a block/blocks there should be documentation of at least 50–70% relief of pain from baseline and evidence of improved function for at least six to eight weeks after delivery.

(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) In the therapeutic phase (the phase after the initial block/blocks were given and found to produce pain relief), repeat blocks should only be offered if there is at least 50–70% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)

(8) Repeat injections should be based on continued objective documented pain 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 as this may lead to improper diagnosis or unnecessary treatment.