

DATE OF REVIEW:

09/04/2007

IRO CASE #:**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Cervical Epidural Steroid Injection with anesthesia under fluoroscopy.

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

Doctor of Osteopathy, Board certified Anesthesiologist, and Specializing in Pain Management.

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.

Cervical Epidural Steroid Injection with anesthesia under fluoroscopy is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Case Report dated 08/21/07
- Referral dated 08/21/07
- Request For Production of Documents dated 08/20/07
- DWC: Notice of Assignment of Independent Review Organization dated 08/20/07
- DWC: Notice of Case Assignment dated 08/20/07
- DWC: Confirmation of Receipt of a Request For a Review dated 08/19/07
- LHL009: Request For a Review By An Independent Review Organization dated 08/15/07
- Letters dated 08/14/07, 07/10/07
- Follow-up Notes dated 08/07/07, 07/09/07, 06/27/07, 05/24/07 from D.O.
- Procedure Report dated 06/20/07, D.O.
- Initial Pain Evaluation dated 08/04/03 from, D.O.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a xx-year-old male with date of injury xx/xx and xx/xx listed. The injured individual had prior neck surgery. He has no MRI or electromyogram (EMG), no radicular findings or complaints, minimal findings to suggest Complex Regional Pain Syndrome (CRPS), and the notes indicate left and right arm pain alternating in each note. He had one epidural steroid injection (ESI) in 06/2007 with no quantification of response or duration of relief.

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

The injured individual has no radicular findings to support this request. There is no EMG or MRI reported. The attending physician (AP) states he is doing it for his CRPS but he does not document that on the procedure report nor are the CRPS findings extensive or overwhelming. Official Disability Guidelines indicate ESIs are indicated to treat radicular pain and are to be repeated only with documentation of adequate symptoms and relief. This has not been supported in the submitted documentation.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

Official Disability Guidelines 2007: Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). 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. 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](#))

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.