



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

DATE OF REVIEW: May 21, 2008

IRO Case #:

Description of the services in dispute:

Preauthorization – Epidural Steroid Injection (ESI) with epidurogram – post injection physical medicine.

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

The physician who provided this review is board certified by the American Board of Anesthesiology in General Anesthesiology and Pain Medicine. This reviewer is a member of the American Society of Anesthesiologists and the American Society of Regional Anesthesia and Pain Medicine. This reviewer has been in active practice since 2002.

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.

Medical necessity does not exist for the requested Epidural Steroid Injection (ESI) with epidurogram – post injection physical medicine.

Information provided to the IRO for review

Records Received From the State:

Fax cover sheet from Pain Solutions, 4/16/08, 1 page

Notice to Medical Review Institute of America, Inc, of case assignment, 5/5/08, 1 page

Confirmation of receipt of a request for a review by an IRO, 5/2/08, 5 pages

Request for a review by an independent review organization, 4/29/08, 3 pages

Letter from CI Rep, 3/31/08, 3 pages

Letter from CI Rep, 4/23/08, 3 pages

Records Received From the Carrier:

Notice of assignment of independent review organization, 5/5/08, 1 page
Initial required medical examination, 2/6/08, 3 pages
Pre-authorization request, 3/26/08, 1 page
Patient notes, 3/31/08-4/22/08, 5 pages

Records Received From Pain Solution:

Notice of assignment of independent review organization, 5/5/08, 1 page
Initial visit comprehensive evaluation, 2/21/08, 4 pages
Reconsideration request, 4/16/08, 1 page
Letter of medical necessity, 4/16/08, 2 pages

Patient clinical history [summary]

The claimant is a female with left shoulder and neck pain. She had a work related injury to her head, neck, and lower back. She is status post physical therapy and cervical decompression discectomy on 11/28/07. The neck pain is intermittent, moderate to severe, 8/10. Her cervical spine MRI (magnetic resonance imaging) on 08/02/07 showed marked loss of disc height with spondylosis at C5-6 and C6-7, both levels demonstrating left neural foraminal stenosis due to protrusion of diskal material into the left intravertebral foramina. Clinical correlation advised for respective left C6 and/or the C7 radicular involvement. There was moderate facet hypertrophy on the left at C4-5 creating neural foraminal encroachment. There was dorsal annular protrusion 3 mm with active annular fissuring of the C3-4 disc. There was diffuse multilevel facet arthropathy, as outlined above. There was mild retrolisthesis C4 on C5. Clinical correlation advised for abnormal biomechanics at this motion segment. There was kyphotic reversal of the cervical spine. The claimant received a cervical spine ESI (epidural steroid injection) on 10/04/07. Her response to the ESI has not been reported. The examination of the cervical spine by her treating physician showed restriction of range of motion due to pain, tenderness on palpation of the midline and bilateral posterior cervical muscles. She had also bilateral occipital tenderness. The treating physician made the following diagnoses: Bilateral suprascapular neuritis, cervical sprain/strain, cervical facet arthropathy, bilateral occipital neuralgia, and myofascial pain syndrome.

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

The claimant's current presentation documented in Dr. 's evaluation is only supportive of myofascial pain syndrome. None of the other diagnoses listed above can be substantiated by the submitted medical records. Further, cervical epidural steroid injection is not an appropriate treatment for the diagnoses listed by Dr. The cervical MRI (magnetic resonance imaging) and EMG (electromyography) mentioned in the submitted records suggested cervical radiculopathy. However, those findings were

from before surgery. The claimant had a CESI (cervical epidural steroid injection) and cervical spine surgery to address this issue, but her pain remained unchanged.

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

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 by physical examination and 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) for guidance
- 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.
- 8) Repeat injections should be based on continued objective documented pain and function response.
- 9) Current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.

ODG –TWC, ODG Treatment, Integrated Treatment/Disability Duration Guidelines, Neck and Upper Back (Acute & Chronic), Epidural steroid injection (ESI).

Peloso PM, Gross AR, Haines TA, Trinh K, Goldsmith CH, Aker P. Medicinal and injection therapies for mechanical neck disorders: a cochrane systematic review. J Rheumatol. 2006 May;33(5): 957–67.

Stav A, Ovadia L, Sternberg A, Kaadan M, Weksler N. Cervical epidural steroid injection for cervicobrachialgia. Acta Anaesthesiol Scand. 1993 Aug;37(6): 562–6.

Castagnera L, Maurette P, Pointillart V, Vital JM, Erny P, Senegas J. Long-term results of cervical epidural steroid injection with and without morphine in chronic cervical radicular pain. Pain. 1994

Aug;58(2): 239–43.

Bush K, Hillier S. Outcome of cervical radiculopathy treated with periradicular/epidural corticosteroid injections: a prospective study with independent clinical review. *Eur Spine J*. 1996;5(5): 319–25.

Cyteval C, Thomas E, Decoux E, Sarrabere MP, Cottin A, Blotman F, Taourel P. Cervical radiculopathy: open study on percutaneous periradicular foraminal steroid infiltration performed under CT control in 30 patients. *AJNR Am J Neuroradiol*. 2004 Mar;25(3): 441–5.

Lin EL, Lieu V, Halevi L, Shamie AN, Wang JC. Cervical epidural steroid injections for symptomatic disc herniations. *J Spinal Disord Tech*. 2006 May;19(3): 183–6.

Beckman WA, Mendez RJ, Paine GF, Mazzilli MA. Cerebellar herniation after cervical transforaminal epidural injection. *Reg Anesth Pain Med*. 2006 May–Jun;31(3): 282–5.

Ludwig MA, Burns SP. Spinal cord infarction following cervical transforaminal epidural injection: a case report. *Spine*. 2005 May 15;30(10): E266–8.