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Notice of Independent Review Decision

July 31, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical epidural steroid injection under fluoroscopy with intravenous sedation, to include #62310, #77003

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

Orthopedic Physician

REVIEW OUTCOME:

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

Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work-related injury on xx/xx/xx, when his right arm was grabbed and twisted. This caused a fracture of the right wrist.

On January 8, 2014, performed open reduction internal fixation (ORIF) of the right radius, right styloid fracture. The postoperative diagnosis was right radius fracture.

On March 26, 2014, evaluated the patient for right hand and wrist pain and color change and nerve symptoms going up the right upper extremity. noted the patient had been initially treated at the emergency room (ER). He had attended 12 sessions of physical therapy (PT) and had utilizing pain medications. obtained x-rays of the right wrist that showed disuse osteopenia in the radius and the ulna as well as the carpal bones. Disuse osteopenia was diagnostic for this reflex sympathetic dystrophy complex regional pain disorder. assessed status post right

distal radius fracture with pinning. This had healed nicely. The patient had the complication of post injury complex regional pain disorder. A neuropathic pain cream was prescribed. Sympathetic ganglion block and PT was recommended as well as Neurontin.

On March 31, 2014, noted the patient had a slight increase in the severity of the right wrist pain. The patient reported no change in the degree of pain in the neck as well as the right shoulder pain. His felt that his right elbow pain was just about the same. Diagnoses were other tenosynovitis of the hand and wrist, other closed fracture of distal end of radius (alone), cervical disc displacement/herniation, disorders of bursae and tendons in shoulder region, unspecified, sprains and strains of elbow and forearm, neuralgia, neuritis, and radiculitis, unspecified, other disorders of muscles, ligament and fascia. Ibuprofen and Ultram were prescribed and PT was recommended. The patient was referred to a pain management specialist.

On April 30, 2014, a pain management specialist, evaluated the patient for right shoulder, arm and hand pain associated with red-hot temperature changes, increased sweat production, swelling, and sensitivity to touch. assessed complex regional pain syndrome (CRPS) following traumatic wrist fracture of the right hand following work-related injury, secondary spread proximally of CRPS with secondary myofascial pain syndrome of the neck and upper back area and moderate reactive depression, insomnia in chronic pain state. prescribed Lexapro, amitriptyline, Norco and gabapentin. Sympathetic blockade was also recommended.

On follow-up dated May 14, 2014, the patient reported noticing left swelling, sensitivity and temperature change in the right hand following institution of care. It was noted that the patient's signs and symptoms were all consistent with the Harden criteria of CRPS. recommended a central cervical epidural blockade.

Per utilization review dated May 23, 2014, the request for cervical ESI with IV sedation, fluoroscopy to include # 62310, #77003, was denied with the following rationale: *"Based upon the medical documentation currently available for review, Official Disability Guidelines (ODG) would not support this specific request to be one of medical necessity. For the described medical situation, the above noted reference does not indicate that treatment in the form of a cervical epidural steroid injection is generally utilized for management of a medical condition of a complex regional pain syndrome. As such, presently, in this particular case, medical necessity for this request is not established per criteria set forth by the above noted reference."*

On May 29, 2014, reported that the patient's complete hand, arm and shoulder continued to be hyperesthetic with moderate temperature changes. It was quite cold that day. The patient was dropping things. He had sudomotor and vasomotor changes. The patient continued to have chronic spasm in his neck, his shoulder and his upper back. He had allodynia and hyperesthesia extending proximally. Hence, a cervical central epidural blockade was recommended.

Hydrocodone was refilled. Home exercise therapy and possible further rehabilitation in conjunction with central cervical epidural blockade.

Per reconsideration review dated June 18, 2014, the request for cervical ESI with IV sedation, fluoroscopy; to include #62310, #77003 was denied with the following rationale: *“This is a male who sustained an alleged workplace injury xx/xx/xx. Pertinent past surgical history includes a January 8, 2014, open reduction and internal fixation of a right radius fracture. The patient complains of pain and swelling in the right upper extremity. The physical examination is significant for hyperesthesia and allodynia in the right upper extremity; chronic spasm in his neck; cold right upper extremity to touch with sudomotor and vasomotor changes. The prior treatment has included: pharmacotherapy, and surgery. A cervical epidural steroid injection with intravenous (IV) sedation and fluoroscopy has been requested by the treating physician due to “central sensitization”. No, the request for cervical epidural steroid injection (ESI) with intravenous (IV) sedation, and fluoroscopy to include CPT codes #62310, and #77003 is not medically necessary or appropriate. The ODG does not specifically address the use of epidural steroid injections for the diagnosis of complex regional pain syndrome (CRPS); however, there is a paucity of medical literature to support the use of epidural steroid injection for complex regional pain syndrome. Additionally, the ODG does not recommend the routine use of sedation except for patients with anxiety. There is no documentation of anxiety that requires IV sedation.”*

On June 25, 2014, noted that the peer-review physician had denied reasonable necessary treatment. The patient's right arm and hand continued to be swollen, hyperesthetic, and painful requiring narcotic, non-narcotic, anti-depressants, and neuropathic pain supports. The patient's oral medications were to be refilled. He had decreased grip strength. The patient had limited use of his right arm approximately 40% of normal.

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

DECISION: The patient has been diagnosed with CRPS and meets the ODG criteria using the modification of the Budapest (Harden) criteria. The Budapest (Harden) Criteria represent a revision of the above IASP Criteria: There are two versions of these proposed diagnostic criteria. A diagnostic version was developed to maximize sensitivity (identify true positive cases) with adequate specificity (i.e. avoiding a false positive diagnosis). A research version was developed to more equally balance sensitivity and specificity. The diagnostic criteria are the following: (1) Continuing pain, which is disproportionate to any inciting event; (2) Must report at least one symptom in three of the four following categories: (a) Sensory: Reports of hyperesthesia and/or allodynia; (b) Vasomotor: Reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry; (c) Sudomotor/Edema: Reports of edema and/or sweating changes and/or sweating asymmetry; (d) Motor/Trophic: Reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); (3) Must display at least one sign at time of evaluation in two or more of the following categories: (a) Sensory: Evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or temperature sensation and/or deep somatic pressure and/or joint movement); (b) Vasomotor: Evidence of temperature asymmetry ($>1^{\circ}\text{C}$) and/or skin color changes

and/or asymmetry; (c) Sudomotor/Edema: Evidence of edema and/or sweating changes and/or sweating asymmetry; (d) Motor/Trophic: Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); (4) There is no other diagnosis that better explains the signs and symptoms.

Per the ODG, CRPS, sympathetic blocks are recommended for limited, select cases, primarily for diagnosis of sympathetically mediated pain and therapeutically as an adjunct to facilitate physical therapy/ functional restoration. When used for therapeutic purposes the procedure is not considered a stand-alone treatment. The role of sympathetic blocks for treatment of CRPS is largely empirical (with a general lack of evidence-based research for support) but can be clinically important in individual cases in which the procedure ameliorates pain and improves function, allowing for a less painful “window of opportunity” for rehabilitation techniques. (Harden, 2013) Use of sympathetic blocks should be balanced against the side effect ratio and evidence of limited response to treatment.

The ODG recommendations (based on consensus guidelines) for use of sympathetic blocks (diagnostic block recommendations are included here, as well as in CRPS, diagnostic tests):

- (1) There should be evidence that all other diagnoses have been ruled out before consideration of use.
- (2) There should be evidence that the Budapest (Harden) criteria have been evaluated for and fulfilled.
- (3) If a sympathetic block is utilized for diagnosis, there should be evidence that this block fulfills criteria for success including that skin temperature after the block shows sustained increase ($\geq 1.5^{\circ}\text{C}$ and/or an increase in temperature to $> 34^{\circ}\text{C}$) without evidence of thermal or tactile sensory block. Documentation of motor and/or sensory block should occur. This is particularly important in the diagnostic phase to avoid overestimation of the sympathetic component of pain. A Horner’s sign should be documented for upper extremity blocks. The use of sedation with the block can influence results, and this should be documented if utilized. (Krumova, 2011) (Schurmann, 2001)
- (4) Therapeutic use of sympathetic blocks is only recommended in cases that have positive response to diagnostic blocks and diagnostic criteria are fulfilled (See #1-3). These blocks are only recommended if there is evidence of lack of response to conservative treatment including pharmacologic therapy and physical rehabilitation.
- (5) In the initial therapeutic phase, maximum sustained relief is generally obtained after 3 to 6 blocks. These blocks are generally given in fairly quick succession in the first two weeks of treatment with tapering to once a week. Continuing treatment longer than 2 to 3 weeks is unusual.
- (6) In the therapeutic phase repeat blocks should only be undertaken if there is evidence of increased range of motion, pain and medication use reduction, and increased tolerance of activity and touch (decreased allodynia) is documented to permit participation in physical

therapy/ occupational therapy. Sympathetic blocks are not a stand-alone treatment.

(7) There should be evidence that physical or occupational therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase.

(8) In acute exacerbations of patients who have documented evidence of sympathetically mediated pain (see #1-3), 1 to 3 blocks may be required for treatment.

(9) A formal test of the therapeutic blocks should be documented (preferably using skin temperature).

In my opinion, the patient meets the criteria for sympathetic blockade and the physician has requested a Cervical epidural approach for blockade. Thus, the procedure is medically necessary as defined per the ODG and the previous decision is overturned. Furthermore, the ODG references epidural infusion which is not recommended. This was utilized for previous denials. However, the requested procedure is not a continuous infusion. Finally, the ODG does not recommend against IV sedation-sedation is not generally necessary for an ESI but is not contraindicated.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES