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Notice of Independent Review Decision

**June 17, 2014**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Second cervical epidural steroid injection at level C4-C5 under fluoroscopy with IV sedation

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

Pain Management 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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who was injured on xx/xx/xx.

**2013:** On September 5, 2013, noted that the patient's symptoms had resolved except for episodes of headaches. The patient had headaches in July and August. The headaches were very severe, but he did not want to be on prophylactic medications. He was utilizing Ultracet and stated that it helped. From the past 10 days, the patient complained of a little bit of neck pain on and off. He stated he wanted to get back on full duty very soon. refilled the Ultracet and recommended follow up in a month.

On October 2, 2013, the patient complained of neck pain and stiffness, though it was very less severe. Examination of the spine revealed some stiffness and limitation in range of motion (ROM). The patient was undergoing physical therapy (PT), but had stopped. The patient did not want to return to full duty, if he actually had neck pain. The patient denied additional muscle relaxant or therapy. recommended computerized tomography (CT) scan of the neck.

On October 17, 2013, CT scan of the cervical spine showed at C3-C4, a 2-3 cm central disc protrusion that abutted and appeared to slightly indent the adjacent cord surface. There was mild central stenosis with a 9 mm AP central diameter. At C4-C5, there was a moderate-to-marked disc narrowing and degenerative changes and a 2-mm diffuse combination disc bulge and osteophyte. There was moderate bilateral unciniate hypertrophy with minimal left and moderate right neural foraminal stenosis. At C5-C6, there was again moderate-to-severe disc narrowing and degenerative changes with a 2-mm combination diffuse disc bulge osteophyte. There was again unciniate hypertrophy greater on the right with mild-to-moderate left and moderate right neural foraminal stenosis coming somewhat more pronounced superiorly on the right.

On October 30, 2013, the patient complained of cervicogenic headaches, neck pain, and stiffness and limited cervical ROM. reviewed the cervical spine CT scan and opined that there was no question that his headaches were cervicogenic in nature. noted that the patient had already done PT and it was doubtful that more therapy would be approved. The medications were helping partially and temporarily only. recommended cervical spinal epidural steroid injection (ESI) with simultaneous bilateral occipital nerve blocks.

**2014:** On January 6, 2014, evaluated the patient for chronic persistent neck pain that was constant and radiating to the left shoulder, mid back and low back. The patient reported that his pain was worse with coughing, sneezing and straining. He was referred for consideration of a cervical epidural blockade. He stated that his pain was 5/10 and could aggravate to 8/10 with minimal reduction with pain medications. There was significant decreased ROM. The patient's history was remarkable for a right hand surgery without sequelae. He was currently utilizing tramadol without benefit. On neck examination, there was decreased left and right rotation at 40 and 60 degrees respectively. He had moderate mid-cervical interspinous tenderness. There was trigger point tenderness in the trapezius, intra-scapular and rhomboid regions. The trigger points were noted in the inter-scapular rhomboid regions. There was mild decrease in pinprick sensation in the C4-C5 distribution on the left. diagnosed chronic neck pain syndrome with cervical disc protrusion having failed conservative, rehabilitative and medical treatment options; cervical spondylosis and myofascial pain syndrome of cervical and upper thoracic regions. noted that the patient's prognosis was poor-to-good and the injection therapy might be beneficial. The patient was recommended the amitriptyline to be increased to 20 mg nightly. The Ultracet was continued.

Per utilization review dated January 29, 2014, the request for outpatient cervical ESI at C3-C4 level under fluoroscopy with IV sedation and trigger point injections at three or more muscle areas was denied.

On February 12, 2014, noted that the patient continued to suffer from daily headaches, mood disturbances, insomnia and chronic pain. The patient continued working. was disappointed at the fact that the patient's request for cervical ESI and trigger point injections was denied. He further opined that if the patient had been approved in a timely manner, he could have had full recovery.

On February 17, 2014, noted that the patient continued with neck pain, shoulder pain, arm pain associated with cervical disc protrusion at C3-C4, C4-C5 and C5-C6. The neck pain radiated in to his shoulders and upper back area. There was occasional pain down into his left arm associated with numbness and tingling. recommended cervical ESI and continued to avoid heavy lifting, bending or twisting or Valsalva maneuver.

Per reconsideration review dated February 25, 2014, the appeal for outpatient cervical ESI at C3-C4 under fluoroscopy with IV sedation and trigger point injection at three or more muscle areas were approved.

On March 3, 2014, noted that he had a telephonic conversation and went over the patient's clinical findings. It was noted that the patient had pain generators most likely above and below the C4-C5 level. He also had twitch response or triggers in the interscapular and rhomboid regions. recommended consecutive trigger injection therapy along with the ESI. agreed to the plan.

On March 17, 2014, noted that the patient was eagerly waiting to undergo the cervical ESI. at this point, recommended going ahead with institution of his care as soon as possible.

On April 1, 2014, performed cervical ESI at C3-C4 down to C4-C5.

On April 3, 2014, expressed appreciation following the cervical epidural block for the patient's cervical disc protrusion at two levels. The patient got excellent relief of the pain with decreased headaches. The patient reported no headaches since the injection. The patient still had trigger point tenderness in the neck and upper back area and numbness. The numbness and tingling down the arm was completely resolved. The patient was off the hydrocodone completely. recommended continuing amitriptyline and avoiding heavy lifting, bending or twisting. A second cervical ESI was recommended. noted that the patient had gotten more than 70% relief with improved functions and decreased medications.

Per utilization review dated April 28, 2014, the request for second outpatient ESI at C4-C5 level under fluoroscopy with IV sedation and trigger point injections at three or more muscle areas was denied with the following rationale: *"Per ODG, treatment in Workers' Compensation requires 50% pain relief of six to eight weeks prior to a repeat epidural steroid injection. The records do not reflect the claimant had the 70% pain relief for six to eight weeks after the previous injection. The records do not reflect objective evidence of radiculopathy on physical examination. The ODG Treatment in Workers' Compensation does not support epidural steroid injection and trigger point injections on the same date. The records do not reflect lower levels of care such as a home exercise program or*

*muscle relaxants as required. There is no documentation of palpation of a twitch response or referred pain. The request for a C4-C5 epidural steroid injection under fluoroscopy with IV sedation and trigger point injections to three or more muscles was not certified."*

On May 12, 2014, noted that the patient was waiting for the second cervical ESI and had 70% improvement of his neck, shoulder and arm pain complaints. His headaches had lessened. His MRI had corroborated with the physical findings including cervical interspinous tenderness, cervical disc protrusion and spondylosis. The patient had continued working. He had been able to cut down his medications and showed functional improvement, decreased medications and decreased pain score. The patient still had mid cervical interspinous tenderness, decreased pinprick sensation in the C5 distribution on the left. refilled the Ultram and scheduled for a second block in the near future.

On May 19, 2014, an appeal/reconsideration for cervical ESI at C4-C5 was made.

Per reconsideration review dated May 23, 2014, the appeal for second outpatient ESI at C4-C5 under fluoroscopy with IV sedation and trigger point injection at three or more muscle areas was denied with the following rationale: *"Per peer reviewer, Deny. The previous non-certification on April 23, 2014, was due to lack of documented sustained pain relief for six to eight weeks after previous injections and lack of objective evidence of radiculopathy on physical examination. Additional documentation was provided for review with the treating physician's office notes from May 12, 2014. The previous non-certification was supported. There is no documentation of 50-70% pain relief for six to eight weeks, as required by the guidelines, with decreased use of medications. There is no objective evidence of radiculopathy on physical examination, with muscle atrophy or loss of relevant reflex, as required by the guidelines. Based upon the medical documentation provided for review and the peer-reviewed, evidence-based guidelines, the request was not medically supported. The appeal request for outpatient, cervical C4-C5 epidural steroid injection, under fluoroscopy with intravenous sedation was not certified.*

On June 2, 2014, a request for IRO was made.

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

The patient underwent a CESI on 4/1/2014. It is documented that the patient had significant relief 2 days post injection and on May 12, 2014, noted that the patient was waiting for the second cervical ESI and had 70% improvement of his neck, shoulder and arm pain complaints. According to the ODG, most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Furthermore, Diagnostic blocks should be at an interval of at least one to two weeks between injections.

1. No more than two nerve root levels should be injected using transforaminal blocks.
2. No more than one interlaminar level should be injected at one session.

Thus, the CESI(cervical epidural steroid injection) under fluoroscopic guidance is certified as it certainly meets the ODG criteria.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**