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May 12, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical ESI 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on xx/xx/xx. The patient was moving x and sustained injury to neck. The exact mechanism of injury was not known.

2009: On May 5, 2009 evaluated the patient for neck pain, some right-sided headache, pain into right thoracic area and into right arm. He reported of having treatment for this, but no benefit. The pain was worse with sitting and standing. Lying down bothered him. He had tried ibuprofen with some help and leftover Vicodin that gave him a headache. He was utilizing Zyrtec for allergies. The review of system was positive for shoulder pain, wrist pain, muscle weakness, sleep disturbances, headache and change in vision. Examination revealed tenderness in right posterior cervical region into the right rhomboids and the right trapezius. Lhermitte's and Spurling's maneuver was positive on right with pain in rhomboids. The impression was cervical syndrome with possible radiculitis on right. recommended physical therapy (PT) and prescribed some Relafen and Skelaxin. If not better, then he was to get magnetic resonance imaging (MRI).

On May 5, 2009, x-ray of the cervical spine revealed some narrowing at C5-C6, but no significant spondylosis or any other abnormalities. He might have a little cervical rib.

From May 5, 2009, thorough June 12, 2009, the patient underwent PT at with modalities to include spine stabilization exercises, biofeedback, manual therapy, mechanical traction, neuromuscular re-education and therapeutic exercises.

On June 2, 2009, noted that the patient was improving and recommended continuing PT. He also noted that they need to document whether or not he had actually more than just a cervical strain syndrome in order to justify his further treatment. The patient was ordered and MRI of the neck to rule out disc protrusion on the right side most likely at C5-C6 and/or C6-C7. The patient was recommended to return after MRI. Skelaxin and ibuprofen was continued.

Per a prescription noted dated June 3, 2009, the patient was prescribed stering Impulse Inferior Unit, electrodes and supplies, dermasoft electrode lumbar garment and vital wrap hot/cold therapy.

MRI of the cervical spine dated June 18, 2009, revealed straightening and minimal kyphosis at C5-C6. The intervertebral disc demonstrated bulging at C5-C6 and C6-C7. At C5-C6, there was disc focal right central protrusion which flattened the ventral right aspect of the cord. There was mild canal narrowing just to the right of midline. At C6-C7, there was focal right central protrusion measuring about 2.4 mm in AP thickness which flattened the ventral right aspect of the cord. The central canal was mildly narrowed to the right of midline. There was asymmetric mild canal narrowing to the right of midline.

On June 19, 2009, reviewed the MRI of the cervical spine and noted the patient was still significantly symptomatic. It was noted that he was laid off from the job and was working elsewhere. recommended cervical ESI and prescribed Relafen and Skelaxin. Darvon was provided.

On July 15, 2009 performed cervical epidural steroid injection under fluoroscopic guidance and epidurography.

On July 29, 2009, noted the patient had significant improvement from the ESI and was having intermittent pain and numbness. He was requiring fewer medications. He stated he was 50-60% better. recommended proceeding with second ESI and continues medications.

On August 19, 2009, performed cervical epidural steroid injection under fluoroscopic guidance and epidurography.

On September 3, 2009, noted dramatic relief in pain from the second injection. recommended holding off on the third injection and increasing activity. noted that he might be at MMI at this junction and might be a candidate for surgery at some point in the future.

On November 16, 2009, saw the patient and noted he had a stress fracture in his foot that caused a little bit of low back pain. He had flared up his neck pain a little bit. He was having occasional numbness in third, fourth and fifth fingers on the right. Spurling's and Lhermitte's maneuver were negative on neck. recommended considering further injections if his neck pain returned.

2010: On February 15, 2010, considered him to be at maximum medical improvement (MMI) and noted that the neurologic symptoms in right arm would continue to improve. released him to full duty at the current point.

On March 15, 2010, a designated doctor evaluation (DDE) on the patient and certified him to have reached MMI on March 15, 2010, with a 0% WPI.

On March 30, 2010, noted the patient had recurrence of his ulnar pain and numbness in the right. recommended repeat ESI.

On April 30, 2010, performed cervical epidural steroid injection under fluoroscopic guidance and epidurography.

On May 6, 2010, noted that the patient had significant relief of his neck pain from the cervical ESI. He still had some numbness intermittently in the ulnar distribution of the right. recommended monitoring and noted he was working full duty at his new job. He was recommended to continue exercising and medications as prescribed.

2011-2013: No records available.

2014: On August 27, 2014, evaluated the patient for ongoing symptomatology. He noted that he currently had neck pain and interferes with his sleep. He had tried melatonin and Benadryl and Ambien which he did not tolerate. Examination revealed that he was sitting comfortably and standing erect. His gait was balanced. Levator scapulae, trapezius and scalenus muscles were tender on the right. The cervical ROM was painful and restricted. Spurling's maneuver was positive on right and negative on the left. The diagnoses were cervical HNP and cervical radicular syndrome. recommended PT 2-3 times a week for 4-6 weeks. He prescribed Lunesta, Flector patch, meloxicam and oxycodone.

From September 30, 2014, thorough November 6, 2014, the patient underwent PT at with modalities to include neuromuscular re-education, manual therapy, therapeutic activities and therapeutic exercises.

On September 30, 2014, noted that the physical therapist said his pain levels were the same and were a little worse than four weeks prior. They needed to see how responsive PT was before considering further treatment planning.

On November 7, 2014, noted the PT had helped his neck, but was still having quite a bit arm symptoms. He had numbness into his third and fourth fingers of

the right third and fourth finger. He had pain down the arm. He was taking less medication. He was able to splint his oxycodone in half and was taking two, occasionally three a day. His symptoms were affecting his activities of daily living. recommended MRI of the neck and refilled oxycodone.

MRI of the cervical spine, performed on November 20, 2014, revealed 3-4 mm right paracentral disc protrusion at C6-C7 level slightly exceeding posterior bony spurs deforming the right anterior aspect of the thecal sac and spinal cord without direct cord contact with mild central canal narrowing. Severe right neural foraminal narrowing was seen. This had a somewhat similar appearance to the prior examination. There was 3 mm broad-based posterior disc protrusion at C5-C6 slightly exceeding posterior bony spurs without signs of cord deformity slightly greater to the right of midline without central canal stenosis. There was moderate bilateral neural foraminal narrowing seen to greater degree than was noted on the prior study. There was neural foraminal narrowing at C2-C3 and C3-C4. There was subtle grade I spondylolisthesis of C7 on T1 with mild bilateral neural foraminal narrowing. There was large muscle retention cyst or polyp within the right maxillary sinus.

On December 9, 2014, reviewed MRI of the cervical spine and noted that it had worsened from his old scan from 2009. The patient still complained of shooting and shocking pains from the neck all the way down to the third and fourth fingers on the right. He generally takes half the oxycodone. ordered cervical ESI at C6-C7.

2015: On January 23, 2015, noted that the cervical ESI was denied and he might be looking as a surgical candidate. had requested surgery of his low back. He continued with symptoms. referred him for surgical opinion on his neck. OxyContin was prescribed.

On January 30, 2015, the patient saw and complained right arm pain and right arm numbness that radiated to the long and ring finger. Examination revealed the upper extremity strength was symmetrical. It was also noted that the radiation of the radicular pain with numbness and paresthesias was at the C7 level. It was also documented that the patient responded favorably to the previous cervical ESI. The diagnoses were C6-C7 disc herniation, cervical spondylosis without myelopathy and cervical radicular syndrome. The plan was for a repeat cervical ESI.

Per utilization review dated February 5, 2015, the request for cervical epidural steroid injection at C6-C7 with IV sedation was denied with the following rationale: *"The clinical information submitted for review fails to meet the evidence based guidelines for the requested services. The patient is a male who reported an injury on xx/xx/xx. The mechanism of injury was not documented within the clinical notes. He is diagnosed with displacement of cervical intervertebral disc without myelopathy. The current medications were noted to include oxycodone. There was no relevant surgical history documented within the clinical notes. The official MRI of the cervical spine, performed on November 20, 2014, revealed 3-4*

mm right central disc protrusion at C6-C7 level. His other therapies were noted to include physical therapy sessions and epidural steroid injections. The subjective complaints on January 30, 2015, included right arm pain and right arm numbness that radiated to the long and ring finger. The physical examination revealed the upper extremity strength was symmetrical. It is also noted that the radiation of the radicular pain with numbness and paresthesias is at the C7 level. It is also documented that the patient responded favorably to the previous cervical ESI. The plan was for a repeat cervical ESI. The Official Disability Guidelines state the criteria for use for ESI are as follows: injections should be performed using fluoroscopy live x-ray for guidance, repeat blocks should only be offered if there was at least 50% pain relief for 6-8 weeks, and repeat injections should be based on continued objective documented pain and function response. The guidelines also state that the use of sedation introduces some potential diagnostic and safety issues. The routine use of sedation is not recommended. The patient presented with right arm pain and numbness. The clinical notes indicate that the patient has had a previous cervical ESI in the past. However, there was a lack of documentation in regard to the least 50% pain relief of 6-8 weeks from the previous injection. Additionally, there was no documentation of objective decrease in pain and increased functional response from the previous injection. Additionally, there was no documentation of objective decrease in pain and increased functional response from the previous injection. Given the above, the request is not supported by the evidence based guidelines. As such, the request is non-certified."

On February 20, 2015, stated he had searched old records were and noted the patient had cervical spine ESI on February 15, 2009, and August 19, 2009, and stated he did well on those. Progress note from May 5, 2009, from indicated the recommendation was that since he had no treatment the plan was to proceed conservatively and order PT. The patient had recurrence of symptoms and in May 2010 and had another injection in his neck. His arm pain was 5/10 and neck pain was 3/10 and after injection on follow up his arm pain was 2/10 and neck pain was 1/10. He did well without until November 2010 when he returned and neck pain was 2/10 and arm pain was 1/10. On examination, upper extremity strength was symmetrical in all extremity muscle group and right leg touch was admirable at C7 and C8 dermatomes. concurred with the cervical ESI for diagnostic and therapeutic purposes as there was positive response previously. recommended follow-up in four weeks.

Per reconsideration review dated March 19, 2015, the appeal for cervical epidural steroid injection at C6-C7 with IV sedation was denied with the following rationale: *"The previous determination stated the request was non-certified as there is lack of clinical documentation of at least 50% pain relief for 6-8 weeks from previous injection and there was no clinical documentation of objective decrease in pain and increased functional response from the previous injection. February 20, 2015, progress note noted old records were researched and the patient had cervical spine ESI on February 15, 2009, and August 19, 2009, and stated he did well on those. Progress note from May 5, 2009, indicated the recommendation was that since he had no treatment the plan was to proceed conservatively and*

order PT. The patient had recurrence of symptoms and on five and in May 2010, he had another injection in his neck and his arm pain was 5/10 and neck pain was 3/10 and after injection on follow up his arm pain was 2/10 and neck pain was 1/10. He did well without until November 2010 when he returned and neck pain was 2/10 and arm pain was 1/10. On examination of February 20, 2015, upper extremity strength was symmetrical in all extremity muscle group and right leg touch was admirable at C7 and C8 dermatomes. This corresponds with MRI of November 2010 when there was severe right neural foraminal narrowing at C6-C7 and C7-T1, there was mild bilateral neural foraminal narrowing. However, objective evidence of improvement in functional capabilities and pain and reduction of medications is not been documented. Therefore, issues raised on initial determination have not been completely resolved. In addition, guidelines do not support sedation for this injection. Recommendation is for non-certification.”

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

There is adequate medical necessity to perform a cervical Epidural Steroid Injection with sedation based on ODG criteria. Patient’s care meets all criteria below.

1. Unresponsive to conservative care
2. Performed using fluoroscopy
3. No more than 2 nerve root levels injected
4. Objective documented relief 50% for six weeks following first injection.

All of the following criteria have been met.

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 be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.

(Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)

8) 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.

9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES