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April 17, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX epidural blockade at XX-XX with fluoroscopy perform under anesthesia.

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:

X Upheld (Agree)

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 XX-year-old XX who sustained an injury on XX. While XX at a XX XX, the patient was XX-XX by a XX approximately XX XX/XX. A XX mechanism of injury was described. The patient noticed intense XX, XX and XX pain radiating into the XX and XX later that evening.

On XX, XX XX, XX. noted the patient had severe XX and XX pain following the injury. The diagnoses were XX strain/sprain, XX sprain/strain and XX. XX therapy (PT) was recommended.

On XX, a magnetic resonance imaging (MRI) of the XX XX revealed findings of XX-XX, XX-XX and XX-XX levels within normal limits. Broad XX mm XX XX was noted at XX-XX and XX-XX levels. Broad XX mm XX XX/XX with a XX mm central component and borderline XX XX XX was noted at

XX-XX level.

On XX, XX XX XX electromyography/nerve conduction velocity (EMG/NCV) revealed XX XX radiculopathy.

On XX, and XX, XX XX, XX. and XX. XX referred the patient to Pain Management for evaluation and possible epidural steroid injection (ESI).

On XX, XX. XX performed a XX ESI at the XX-XX level under fluoroscopic guidance.

On XX, XX. XX noted the XX pain and XX XX XX pain was improved after the ESI. PT was continued and follow-up with XX. XX was recommended. (Partially illegible handwritten note).

On XX, XX. XX referred the patient to XX, for evaluation and treatment for persistent XX pain.

On XX, XX. XX saw the patient for chief complaint of chronic persistent XX, XX XX, XX and XX pain associated with numbness, weakness and tingling following a work accident on XX. Since this time, XX had PT, rehabilitative medical treatment options. XX admitted having XX XX, XX, XX pain and pain below the XX. Reportedly, XX had tried numerous drug regimens and unfortunately XX pain continued. XX presented for consideration of ESI or XX epidural treatment for XX persistent XX pain as XX wanted to get XX to XX formal XX XX and activities of daily living (ADLs). MRI of the XX XX showed a central XX XX to the XX at XX-XX. Of note, the patient's XX pain was worse with coughing, sneezing, lifting and bending. As a result of this continued pain, XX was getting XX XX. In fact, XX XX showed 9/22 responses suggestive of XX to XX XX XX. XX ORT or risk for XX misuse was low risk 3/10. XX GAD-7 was 2/21. XX was under XX family physician's care for many years for XX. The XX exam revealed supple with decreased XX rotation 30 degrees pain with flexion. The patient had mid XX interspinous tenderness at XX-XX and XX-XX. XX had impulse pain with a positive XX testing into the XX XX. XX had decreased grip strength in the XX XX-XX distribution. Trigger points were determined in the XX XX region. XX flexion was 40 with flexion, 20 degrees extension with moderate pain on the extension. Facet tenderness was noted. XX XX pain was aggravated with side bending. Straight XX raising (XX) test showed XX tightness 80 degrees XX. No sudomotor or vasomotor changes were noted. The assessment was chronic XX pain syndrome with XX XX radiculopathy consistent with XX XX XX and XX XX radiculopathy having failed conservative rehabilitative care following XX injury; XX pain syndrome of the XX mid XX XX regions; XX facet syndrome (mechanical XX pain syndrome) associated with chronic XX pain syndrome with XX XX radiculopathy consistent with XX XX XX and XX XX radiculopathy having failed conservative rehabilitative care following XX injury and XX pain syndrome of the XX XX XX regions; XX XX disruption with XX XX XX XX-XX associated with chronic XX pain syndrome with XX XX radiculopathy consistent with XX XX XX and XX XX radiculopathy. XX. XX planned a XX blockade.

On XX, XX. XX completed a pre-authorization request for the XX blockade.

On XX, XX XX, XX. completed a Utilization Review and denied the request for epidural blockage at XX-XX on the basis of the following rationale: “The patient sustained an injury on XX. The patient has XX and XX XX pain. The patient had 2/21 on the XX score. MRI showed an HNP at XX-XX. The patient had XX XX and reduced XX grip. The patient has had XX therapy. The patient was a candidate for the epidural steroid injection given the MRI and exam findings. However, the patient had no overt XX nor was being treated for XX nor document the patient have any compromising medical issues to support sedation. Therefore, the request was not medically necessary.”

On XX, XX notified XX. XX about non-certification of the XX blockade.

On XX, XX. XX noted the patient continued to have pain into XX XX XX and XX. Once again, XX represented XX and XX associated with this injury. Once again, XX wanted the standard of care in anesthesia. XX. XX needed so on the monitor and sedate this patient appropriately so the XX-XX interspace utilizing a catheter approach would go without side effect or complication. XX. XX resubmitted the request for the XX blockade.

On XX, XX, XX. completed a reconsideration and denied the request for epidural blockage at XX-XX on the basis of the following rationale: “*The patient sustained an injury on XX. The patient has chronic XX pain with radiculopathy with MRI showing central XX XX to the XX at XX-XX. The patient recently started treatment with XX and XX. Follow-up on the benefits provided by those medications, if any, are not included in the available records. The patient has previously a XX epidural steroid injection(ESI) at the same level as the current request on XX, with follow-up on XX. There is no evidence of persistent relief from the previous ESI or assertion that the previous ESI was incorrectly placed in order to justify the pursuit of a repeat ESI. Therapeutic ESIs are generally recommended only as adjunct therapy intended to enable or better enable patient participation in active rehab efforts. Such engagement has been shown to provide long-term relief. In the absence of evidence that patient received transient relief from the most recent ESI such that improved engagement became possible, it is unclear of what the purpose of repeating the ESI is. Compliance with the aforementioned guidelines and medical necessity are not established with the information in the available medical records. Thus, the request is non-certified.”*

On XX, XX notified XX. XX about the denied decision.

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

Patient had a CESI XX. According to the records, XX, XX received good relief of XX pain and

XX XX XX pain improved as well. Feeling has come XX to the XX XX XX but not the XX XX. There is no documentation in regards to percentage of relief and duration of relief after the first injection. As per the ODG (outlined below), In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for XX to XX weeks, with a general recommendation of no more than XX blocks per region per XX. Repeat injections should be based on continued objective documented pain and function response.The ODG criteria is not met. Therefore, the request for a second CESI is non-certified at this time.

Epidural Steroid Injection (ESI) – XX

Recent evidence: XX

While not recommended, XX

Criteria for the use of Epidural steroid injections, diagnostic: To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below: 1) To help to evaluate a pain generator when XX signs and symptoms differ from that found on imaging studies; 2) To help to determine pain generators when there is evidence of multi-level nerve root compression; 3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g. XX distribution), and imaging studies have suggestive cause for symptoms but are inconclusive; 4) To help to identify the origin of pain in patients who have had previous XX surgery.

☐ Medically Necessary

X Not Medically Necessary

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES