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March 4, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX-sided transforaminal epidural steroid injection (TFESI) at XX-XX and XX.

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 was XX on XX, while XX a XX XX.

On XX, a magnetic resonance imaging (MRI) of the XX XX performed at XX, interpreted by XX, XX The study showed multilevel degenerative changes most pronounced at XX-XX, where there was at least moderate encroachment on the XX XX recesses, possibly intermittently impinging on the traversing XX XX nerve root as it arises from the XX XX. XX XX lateralizing XX XX and XX XX counters the XX XX and XX XX XX and XX nerve roots, possibly affecting them. (Poorly scanned record)

On XX, an MRI of the XX XX performed at XX, interpreted by XX. The study showed multilevel malalignment with XX mm XX at XX-XX and XX mm XX at XX-XX, and all levels from XX-XX inferiorly to XX-XX. The XX XX degenerative changes were noted with multilevel XX XX, slight XX narrowing and anterior/marginal XX XX. At XX-XX, there was a broad-based XX posterolateral/extraforaminal XX protrusion with an XX XX which abuts the undersurface of the exiting XX XX XX XX or XX with potential for mass effect. XX and small XX XX contributed to multilevel foraminal narrowing as follows: Mild XX at XX-XX, mild XX and moderate XX at XX-XX, moderate XX at XX-XX and XX-XX. There was no significant XX XX XX XX in the XX XX. Partially visualized were numerous large XX XX arising from the XX XX of the XX XX, the largest measuring was XX X XX cm.

On XX, x-rays of the XX XX showed no significant offsets in the XX alignment. The XX heights were well-maintained. The XX spaces were well-maintained. There were XX XX type XX bodies, XX was therefore transitional. There was a XX XX to the XX with the maximum XX at XX/XX. There was a mild narrowing of the XX/XX XX space. Endplate XX from XX-XX were noted. Surgical clips were noted in the XX upper XX likely secondary to status post XX.

On XX, an MRI of the XX XX performed at Minimally Invasive XX, interpreted by XX, XX The study showed multilevel degenerative changes with multilevel XX and XX XX. The XX space narrowing was greatest at the XX-XX. There was minor XX of XX on XX, XX on XX and XX on XX. There was mild to moderate XX foraminal narrowing at the XX-XX and XX-XX.

On XX, XX, XX, saw the patient for the complaints of midline XX XX pain and XX pain that radiated down the posterior XX to the XX. XX had more than 50% pain relief with functional improvement with XX current medications without side effects. XX had a follow-up with XX, XX Surgeon, on XX. XX (XX) completed on XX, was consistent with the medications prescribed. The examination showed a decreased XX range of motion (ROM), increased pain with ROM, tenderness over the XX XX, decreased XX XX XX strength and positive straight XX raise (XX). The patient was not using assistive devices and showed no evidence of foot drop. The gait was antalgic. The diagnoses were XX radiculopathy, other XX XX displacement of the XX region, XX without XX or radiculopathy of the XX region and lower XX pain. XX was prescribed. XX was discontinued due to no significant improvement in symptoms.

From XX, through XX, XX. XX saw the patient for persistent XX XX pain with radiculopathy to the XX XX. The examination showed decreased ROM, joint stiffness, joint pain, tenderness, positive facet loading test at XX-XX and XX-XX, decreased XX XX XX strength and DTRs ¼ XX XX and XX. The gait was antalgic. XX was refilled, and home exercise program (XX) was continued. On XX, the patient was scheduled for XX XX-XX and XX-XX XX facet joint blocks for a diagnostic purpose. If more than 50% relief obtained with blocks, then proceeding with XX XX was recommended. On XX, SOAPP-R score was 9 (low risk of XX use).

On XX, XX performed XX XX-XX and XX-XX XX blocks at XX XX XX & XX. The diagnosis was XX XX XX dysfunction.

On XX, XX noted the patient was status post XX XX-XX and XX-XX XX XX XX blocks with more than 80% relief for XX-to-XX hours. XX UDS was consistent with the medications prescribed. Continuation of XX and XX was recommended. XX was scheduled for XX XX-XX and XX-XX XX facet joint XX.

On XX, XX. XX performed XX XX-XX and XX-XX XX facet XX at XX XX xX & XX. The diagnosis was XX XX joint pain.

From XX, through XX, XX. XX noted the patient had more than 80% relief with the XX-sided XX-XX and XX-XX XX facet XX. XX continued to have XX more than the XX-sided XX XX pain. XX had XX-sided XX XX pain and occasional XX pain that radiated down the posterior XX to the XX. XX also had occasional XX XX weakness due to the pain. On XX, SOAPP-R score was 11. XX was taking OTC XX for good pain relief. On XX, UDS was consistent with the medications prescribed. The additional diagnosis was XX without XX or radiculopathy of the XX region. The XX-sided XX-XX and XX-XX XX facet XX was scheduled. XX and XX were continued.

On XX, through XX, XX. XX noted the patient continued to have XX XX XX pain and occasional XX pain that radiated down the posterior XX to the XX. The pain was described as numbness, tingling and aching. XX had XX XX XX weakness secondary to the pain. XX had more than 50% pain relief and functional improvement with the current medications without side effects. XX was pending for the XX-sided XX-XX and XX-XX XX XX joint XX. On XX, SOAPP-R score was 6. On XX, XX reported XX XX pain and XX XX pain radiating to the lateral XX and XX more than the XX XX XX weakness secondary to the pain. XX and XX were continued.

From XX, through XX, XX. XX noted the patient continued to have XX greater than the XX XX XX pain and XX pain that radiated down the posterior XX to the XX and XX XX XX weakness due to the pain. The patient was stable on current medications with no aberrant behavior. SOAPP-R score on XX, was 4. XX and XX were continued. The patient was scheduled for the XX-sided XX-XX and XX-XX XX facet XX.

On XX, XX. XX performed the XX-sided XX-XX and XX-XX XX facet XX. The diagnoses were XX facet joint pain and XX strain/sprain.

Per a postprocedure call dated XX, the patient had a little soreness, but XX did work.

On XX, and XX, XX. XX noted the patient had 85% relief after the last XX-sided XX-XX and XX-XX XX facet XX. XX reported XX-sided lower XX pain with radiculopathy and XX XX XX weakness. XX had improvement with current medications. XX-sided XX-XX and XX-XX XX facet XX was recommended. XX, XX and OTC NSAIDs as needed were continued.

On XX, XX. XX performed XX-sided XX-XX and XX-XX XX facet XX at XX & XX.

On XX, XX. XX noted the patient had more than 50% relief with the XX-sided XX XX. XX complained of the XX more than the XX XX XX pain that radiated to the posterior and lateral XX and XX more than the XX extremity weakness. XX had improvement with sitting. XX had more than 50% pain relief and functional improvement with the current medications. UDS performed on XX, was consistent with the prescribed medications. The additional diagnosis was chronic pain syndrome. XX-sided XX-XX and XX-XX TFESI to improve the patient's discogenic and radicular symptoms was recommended. XX, XX and OTC NSAIDs as needed were continued. The patient was advised to consider repeat XX MRI if had no improvement with conservative treatment.

On XX, correspondence from XX indicated the patient was notified about the denial of requested services.

Per Utilization Review dated XX, the request for XX-sided TFESI at XX-XX and XX levels was denied by XX, XX Rationale: *"The request for the XX TFESI at XX-XX and XX was not medically necessary. As noted in ODG's XX XX Chapter Epidural Steroid Injections, Therapeutic topic, the use of epidural steroid injections for chronic pain is associated with a decreased success rate. Here, the attending provider failed to furnish a clear or compelling rationale in favor the decision to employ epidural steroid injection therapy as the late stage in the course of the claim as of the date of the request, i.e., approximately XX years removed from the date of injury as of the date of the request. ODG further stipulates that repeat injection should be based on sustained analgesia on the order of at least 50-70% for at least XX-XX weeks. Here, however, the fact that the patient had derived only 30% analgesia with the prior epidural block, the attending provider's failure to report the patient's work and functional status, and the patient's continued reliance on XX and non-XX agents to include XX, XX and XX, taken together argued against the patient's having derived requisite improvements in the functional with receipt of at least one prior such injection. The request for a repeat injection is not, thus, indicated. Therefore, the request is not medically necessary."*

On XX, XX. XX appealed on behalf of the patient for denial of the XX TFESI. The patient complained of the XX more than the XX XX XX pain that radiated down the posterior and lateral XX. XX also complained of the XX more than the XX extremity weakness due to the pain. XX had more than 50% pain relief and functional improvement with the current medications without side effects. XX had a history of a XX ESI completed on XX, which had given more than 50% pain relief and functional improvement for XX months after the procedure. XX had completed a course of XX therapy (PT) for the XX XX in XX with no significant benefit. XX was doing XX on a XX basis as tolerated. The examination showed increased pain and decreased ROM of XX with function. The SLR was positive on the XX. There was decreased strength of the XX XX. There was decreased XX posterior and lateral XX XX sensation. XX was not using assistive devices for XX with no evidence of XX drop. XX had a XX-sided antalgic gait. Based on the patient's history, physical findings and imaging the patient was an ideal candidate for a XX-sided XX-XX and XX TFESI to improve XX XX and radicular symptoms. XX had also tried and exhausted conservative treatment which included pain medications, muscle XX and anti-inflammatory medications. Given all these reasons, the request for XX-sided XX-XX and XX TFESI was re-submitted to improve the patient's

discogenic and radicular symptoms. (Illegible printed record)

Per a correspondence from XX dated XX, XX. XX was notified about upheld of the requested XX XX-XX and XX TFESI.

Per Reconsideration dated XX, the request for XX XX-XX and XX TFESI was upheld by XX, XX Rationale: "ODG XX XX (updated XX)-Online Version. "*XX. For these reasons, the requested appeal for XX TFESI at XX-XX and XX is not medically necessary."*

On XX, XX. XX noted the patient continued to have XX XX pain radiating down the posterior and lateral XX. XX had the XX greater than XX lower extremity weakness secondary to pain. The pain was aggravated with changing from a sitting to standing position. XX had improvement with sitting and XX. XX had greater than 50% pain relief and functional improvement with XX current medications with no side effect. On exam, the XX XX had increased pain and decreased ROM with XX flexion. The SLR was positive. There was a decreased sensation in the XX posterior and lateral lower XX. XX was refilled. XX-sided XX-XX and XX TFESI was recommended to improve XX XX and radicular symptoms. The patient was advised to continue with XX. XX. XX recommended considering XX MRI if the patient had no improvement with conservative treatment.

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

The patient is a XX-year-old individual who sustained an injury on XX.

Epidural Steroid Injection (ESIs), therapeutic, recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. Per the ODG, radiculopathy (due to XX XX XX, not XX XX) must be documented. The previous XX MRI, XX and XX did not reveal evidence of XX XX or XX impingement. The XX XX MRI report noted XX XX impingement.

Per the ODG guidelines regarding XX radiculopathy and epidural steroid injections, the treating provider must present documentation and corroborate with objective data (imaging or electrodiagnostic testing) for which this case does not include documentation or electrodiagnostic testing data. At this time, there is no imaging or electrodiagnostic data to corroborate the clinical impression of a XX XX and XX radiculopathy. The previous ESI was a caudal ESI with noted >50% relief x XX months with functional improvement. However, the epidural being requested is a XX TFESI at XX-XX and XX. There is no new evidence to corroborate and justify a 2 level transforaminal ESI at this time. Thus, it cannot be deemed to be medically necessary.

☐ 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