CALIGRA MANAGEMENT, LLC
344 CANYON LAKE
GORDON, TX 76453
817-726-3015 (phone)
888-501-0299 (fax)

March 19, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX XX block injections (CPT codes: XX injection for nerve block)

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 Overturned (Disagree)

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 a work-related injury on XX. The patient was XX a XX XX from the XX XX when XX was XX, resulting in burning pain, numbness and tingling at the XX XX. XX noted XX XX with an XX XX.

On XX, the patient was seen by XX, in an initial evaluation at the XX. The patient presented with complaints of numbness in the XX XX and XX. The patient also had some numbness and weakness in the XX XX and XX. On examination, there was mild swelling along the XX XX. There was mild decreased strength in the XX XX. There was mild numbness to the XX and XX aspect of the XX XX of the XX XX. The diagnosis was XX numbness. The patient was advised to use a warm compress and avoid activities which worsen the condition.

On XX, the patient was seen by XX, in an initial office visit. The patient reported constant and moderate aching in the XX. XX complained of tenderness to palpation (TTP) over the XX XX. The pain was sharp and intermittent. XX stated XX XX XX XX was significantly better. The examination showed decreased strength in the XX XX, especially with XX grip. There was mild numbness to the XX XX along the XX and XX aspect involving the second to XX XX. The numbness was extending to the XX XX. There was decreased sensation in the XX XX and XX XX. It was noted that when the patient placed the XX on a hard surface, XX had intense pain. The diagnoses were XX numbness, XX XX weakness, XX XX and XX XX pain. The patient was referred to a Neurologist.

On XX, the patient was seen by XX, for persistent pain in the XX XX XX, XX XX and XX XX. The pain was sharp, aching and shooting. The pain level was 10/10. XX continued to have numbness and tingling in the XX XX and XX. There was no sign of XX XX XX or any sign of XX or XX of XX XX. The recommendations included medication management with XX and referral to Neurology. The patient was released to full duty without restriction.

On XX, the patient was seen at the XX for persistent pain, tingling and numbness in the XX XX XX, XX and XX. XX was prescribed.

On XX and XX, the patient was evaluated by XX for persistent pain, tingling and numbness in the XX XX XX, XX and XX. XX also complained of constant pain in the XX XX. The pain level was 7/10. The examination showed decreased strength of the XX XX. There was tenderness over the posterior aspect of the XX XX, medial aspect of the XX XX, XX XX, XX XX and XX XX. There was decreased sensation to light touch to XX XX and XX. XX was stopped. Neurology consultation was pending.

On XX, XX, evaluated the patient for XX XX pain. The physical examination was unremarkable. An electromyography/nerve conduction velocity (EMG/NCV) of the XX extremities (XX) was performed at the XX. The NCV revealed a reduction in the amplitude of the evoked response of the XX XX motor nerve and XX axillary motor nerve compared to the XX. The study was abnormal with evidence consistent with injury to the XX XX of the XX XX XX without associated denervation. XX ordered a magnetic resonance imaging (MRI) of XX XX, recommended physical therapy (PT) and prescribed XX.

On XX, the patient was seen by XX for persistent XX XX complaints. The XX medication was XX. The MRI was pending.

From XX through XX, the patient attended PT at the XX.

On XX, an MRI of the XX XX was unremarkable. Incidental finding of a probable large chronic XX XX present in the XX XX XX causing some mild XX to XX midline shift.

On XX and XX, XX reviewed the MRI and recommended PT.

On XX, the patient was seen by XX for sharp and stinging pain in the XX XX. XX was prescribed. The patient was referred to Occupational Medicine.

From XX through XX, the patient was evaluated by XX for complaints of pain in the XX, XX, XX and XX XX, XX more than the XX. The pain was constant and radiating to the XX UEs. The pain was increased with XX. The pain level was 8/10. The diagnoses were pain in the XX, XX, XX XX and long-term use of other medications. XX, XX, XX and XX were prescribed.

On XX, the patient was seen at the XX and XX for additional therapy for the XX XX pain. Therapy was recommended XX times a week for XX weeks.

On XX, XX saw the patient for ongoing XX XX pain. The diagnoses were XX XX, XX XX and complex regional pain syndrome (CRPS) of the XX XX extremity (XX). The patient was referred to Pain Management.

From XX through XX, the patient attended chiropractic therapy at the XX.

On XX, the patient was seen by XX for persistent pain in the XX and XX XX. The pain was worse with movement, increased activity and XX. The diagnoses were XX XX, XX XX, pain in the XX, XX and XX XX. XX medications were continued.

On XX, XX, saw the patient for ongoing XX XX pain. XX XX XX was noted. XX recommended continuing conservative treatment for the XX injury.

On XX, XX, completed a Designated Doctor Examination (DDE). XX opined according to the compensable diagnosis as XX XX, the patient had reached maximum medical improvement (MMI) on XX, with XX% whole person impairment (WPI), and no further medical recovery could be expected for this type of injury. With regards to the scenario with the inclusion of XX and XX of the XX as the extent of the injury, continued treatment was being contemplated. Such treatment would include sympathetic blocks. The patient would reach MMI on or about XX.

On XX, XX, saw the patient for XX XX pain. The physical examination revealed limited abduction with sharp pain and tingling going to the XX XX. X-rays of the XX XX revealed loss of XX XX. The XX XX x-rays revealed type II (XXmm) XX, a normal/degenerative XX (XX) joint and normal AHD at XX mm. The diagnoses were XX and XX, pain in the XX XX and XX of an unspecified degree of the XX XX. Previous MRI of the XX was reviewed. Neurology consultation was recommended for the XX XX.

XX, a correspondence from XX indicated the request for a XX XX block injection between XX and XX was certified.

On XX, XX performed a XX XX XX block.

On XX, XX saw the patient for XX XX pain and tingling. The patient had tried manipulation, medications, rest, injections and heat in the past to relieve XX pain. The pain was relieved by 80% since the injection. The history was notable for XX XX, XX, XX, XX XX, XX and a XX XX of the XX. Surgical history was notable for XX removal. The patient was on XX, XX, XX, XX patch, XX, XX and XX with around 20% pain relief. The XX XX examination revealed painful XX flexion anteriorly. The range of motion (ROM) was full. The XX strength was 3/5 in the flexors and extensors. The XX XX was cold to touch/XX noted in the XX. XX, XX and XX were continued. XX and XX were discontinued. A XX XX XX block was performed.

On XX, XX. XX noted 100% pain relief for XX day since the injection. XX had increase in temperature and significant pain relief. Repeat XX XX XX block was performed. XX, XX and XX were continued.

On XX, XX. XX noted increased pain in the XX with numbness and tingling and coldness. XX was not able to XX XX XX due to decreased ROM and increased pain. Repeat XX XX XX block was recommended.

From XX through XX, the patient underwent therapy sessions at the XX.

On XX, XX and XX, XX. XX noted pain with XX lateral XX XX rotation and XX lateral flexion. The patient did not find any relief with the recent injection. The patient had increased XX XX, XX and XX pain and decreased ROM. XX had tried injections in the past with significant pain relief. XX, XX, XX and XX were continued and a XX XX block was recommended.

On XX, XX. XX completed a Letter of Medical Necessity. XX. XX opined the XX XX block was an appropriate treatment for the patient. XX medical history was significant for XX XX to the XX, XX XX, XX XX disorder and XX. XX was status post XX XX block on XX with 80% pain relief for XX hours and on XX with 100% pain relief for XX days. XX had failed PT with limited success. Hence a XX XX block would be beneficial to the patient.

On XX, XX. XX completed a preauthorization request for XX XX XX blocks.

On XX, XX, completed a utilization review and denied the request of XX XX XX block injections. The rationale for denial: *“In my judgment, the clinical information provided does not establish the medical necessity of this request. The patient has a diagnosis of complex regional pain syndrome, and the provider is requesting XX XX blocks. It is noted the patient had prior similar injections, but documentation did not objectively identify improvement as noted by an increased range of motion, a decrease in pain medication intake, or other objective measures of efficacy. It is simply stated the patient had "significant pain relief." As such, this request for XX XX XX block injections (CPT Codes: XX Injection for nerve block) is not medically necessary.”*

On XX, XX completed an appeal letter on behalf of the patient. The XX XX block treatment was consistent with the ODG. During the preauthorization decision time, the patient's physical condition was XX because of the refusal to approve the XX XX XX block injections, which was preventing XX. XX from fully utilizing the necessary treatment options to allow the patient to reach MMI.

On XX, XX XX, performed reconsideration and denied the request for XX XX XX block injections. The rationale for denial: "*In my judgment, the clinical information provided does not establish the medical necessity of this request. On XX, peer review #XX non-certified XX XX blocks. It was noted that the injured worker had prior similar injections. The documentation did not objectively identify improvement as noted by an increased range of motion, decreased pain medication intake, or other objective measures of efficacy. The documentation simply stated that the injured worker had significant pain relief. A XX appeal letter notes that the injured worker's condition is deteriorating because of the refusal to approve the XX XX blocks. In reviewing the previous documentation, a progress report by XX. XX on XX, indicates that the injured worker was status post XX XX XX block providing 100% pain relief for XX days and 50% ongoing. However, a subsequent XX letter of medical necessity notes that the injured worker was status post XX XX block on XX, that provided 80% pain relief for XX hours and on XX, that provided 100% pain relief for XX days. Guidelines advise that in the therapeutic phase repeat blocks should only be undertaken if there is evidence of an increased range of motion, pain and medication use reduction, and increased tolerance of activity and touch (decreased XX) is documented to permit participation in XX therapy/XX therapy. The appeal letter did not clearly indicate an increased range of motion, decreased medication use, and increased tolerance of activity and touch. The previous injections only afforded the injured worker up to XX days of relief according to the XX letter of medical necessity, which appears to conflict with the information in the XX report which noted 100% pain relief for XX days and 60% ongoing. Clarification regarding the injured worker's precise response to each of the administered a XX XX block is necessary before additional consideration for further blocks. The appeal for XX XX XX block injections (CPT Codes: XX Injection for nerve block) is not medically necessary.*"

On an unknown date, a correspondence by XX. XX in support of the patient was documented. Rationale: "At the conclusion of history and physical examination and to a reasonable medical probability, the patient suffered from XX, temperature asymmetry, weakness of the XX, XX and limited ROM of the affected XX. Therefore, there was no other diagnosis to explain the patient's signs or symptoms, but XX type 1, for the above and below-referenced reasons, the relevant clinical and examination findings, the relevant medical history and the symptom timeline. The patient's symptoms and medical records support a diagnosis of XX type I. The plan was to provide the patient with XX because of its inhibition of NE XX which is important for nerve pain. A XX XX XX block, which could be diagnostic and therapeutic. Virtually every part of the body can be injured by an XX XX. The extent of the injury will depend on many factors including the nature of the tissue and the amount and duration of the XX XX. In addition, XX and XX XX can be induced by a number of mechanism with little or no Immediate tissue damage. XX can be caused by the XX of the XX by XX XX and by another mechanism. XX tissue has the least resistance to

XX flow and is thus more easily damaged. XX nerves may be directly injured by XX flow through them or by a XX syndrome involving nerves far removed from the points of contact. XX XX and XX have been reported following XX XX to the XX that produced small (2%) or no XX XX. XX XX system damage from XX XX can lead to XX that may be responsive to sympathetic block. XX has been divided into different stages. Depending on the nature of the injury, the stages vary in their duration. Stage I is a sympathetic dysfunction with the typical XX distribution of the pain. The pain may spread in a mirror fashion to a XX extremity or to adjacent regions on the same side of the body. In stage I, the pain is usually XX in nature. Currently, the patient is in stage I. XX play a major role in the management of pain and inflammation in the XX and XX XX system. Depriving the patient of proper pain medication can aggravate the immune system dysfunction. The selection of proper XX for the treatment of XX is quite critical. Both XX XX and mixed uploads XX-XX have been used for the treatment of pain with XX. XX are considered effective in the treatment of XX pain. Nerve blocks may be diagnostic, therapeutic or both. XX is also indicated for XX."

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

ODG for XX XX blocks: Recommendations (based on consensus guidelines) for use of sympathetic blocks: (1) In the initial diagnostic phase if less than 50% improvement is noted for the duration of the local anesthetic, no further blocks are recommended. (2) In the initial therapeutic phase, maximum sustained relief is generally obtained after XX to XX blocks. These blocks are generally given in fairly quick succession in the XX XX weeks of treatment with tapering to XX a XX. Continuing treatment longer than XX to XX weeks is unusual. (3) 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 XX) in XX therapy/XX therapy. (4) There should be evidence that XX or XX therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase. (5) In acute exacerbations, XX to XX blocks may be required for treatment. (5) A formal test of the block should be documented (preferably using skin temperature). (6) 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. Repeated blocks are only recommended if continued improvement is observed. Systematic reviews reveal a paucity of published evidence supporting the use of local anesthetic sympathetic blocks for the treatment of XX and usefulness remains controversial. Less than XX/XX of patients with XX are likely to respond to sympathetic blockade. No controlled trials have shown any significant benefit from sympathetic blockade.

XX XX block (XX) (XX sympathetic block): XX

In this case, the patient had two positive diagnostic XX, (>50% improvement for the duration of the

local anesthetic). In the therapeutic stage, maximum sustained relief is generally obtained after XX to XX blocks. These blocks are generally given in fairly quick succession in the XX XX weeks of treatment with tapering to XX a XX. In my opinion, the patient did not have adequate therapeutic phase blocks. Therefore, XX XX XX block injections in quick succession are certified. However, 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 XX) in XX therapy/XX therapy. There should be evidence that XX or XX therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase. A formal test of the block should be documented (preferably using skin temperature). A XX sign (XX XX, XX, XX conjunctival engorgement, and warmth of the XX) indicates a sympathetic block of the XX and XX. It does not indicate a sympathetic block of the XX extremity. Documentation of motor and/or sensory block should occur. Repeated blocks are only recommended if continued improvement is observed.

X Medically Necessary

☐ 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