

Clear Resolutions Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726

DATE OF REVIEW:

JUNE 25, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Neurolytic sympathetic block with phenol under fluoroscopic guidance

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

American Board

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office notes, Dr., 08/23/06 and 08/30/06
Office note, Dr., 09/06/06
Office notes, Dr. 09/14/06, 09/19/06 and 10/13/06
Note from Dr. to Dr., 09/14/06
Right ankle MRI with and without contrast, 09/15/06
Foot MRI, 09/15/06
Office notes, Dr., 09/22/06, 11/02/06, 12/01/06, 12/19/06, 01/30/07, 02/13/07, 03/06/07, 04/10/07, 05/08/07, 05/21/07 and 06/05/07
Notes from, 10/02/06, 05/24/07 and 05/31/07
Review, Dr., 10/10/06
Note, Dr., 01/15/07
Work status report, Dr., undated
Peer review, Dr., 05/23/07
Pre-authorization request, undated

Peer review, Dr., 05/30/07
Request for review, 05/31/07
Note from Attorney, 06/12/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient is a female who sustained a severe injury to her right leg as a child which required multiple surgeries and flap repairs. On xx/xx/xx a cart carrying approximately 4, 20 gallon containers of beverage ran over her right leg and struck her tibia. Dr. evaluated the Patient on xx/xx/xx and xx/xx/xx for right foot pain traveling up the right leg and ankle pain. X-rays of the right foot showed no acute fracture. She was diagnosed with a right foot contusion and right lower leg pain and a moon boot, Ibuprofen, Naproxen, therapy and light duty were prescribed. Dr. saw the Patient on 09/06/06 for continued right foot and ankle pain radiating to the lower tibial area. X-rays of the right tibia/fibula were noted to show a prior surgery with no acute fracture. X-rays of the right foot were noted to show a possible fracture at the base of the fifth metatarsal/cuboid. Referral to Dr., podiatrist, continuation of the boot, rest, Ultracet and light duty were recommended.

Dr. examination on 09/14/06 demonstrated significant guarding with range of motion of the ankle and subtalar joint and with attempted plantar flexion of the toes producing pain throughout the entire dorsal aspect of the foot and ankle. There was pain with light touch and a large soft tissue deficit to the proximal leg from the multiple previous surgeries. Dr. felt that early complex regional pain syndrome was possible, but she did not have any classic symptoms to suggest that. Lower extremity injury with pain out of proportion to the symptoms was diagnosed. A BK walker and continuation of modified duty were ordered.

An MRI of the right ankle on 09/15/06 demonstrated a small and ill defined foci of T2 hyperintensity within all of the osseous structures of the ankle of various degrees of mild to moderate enhancement after gadolinium administration, possibly representing resorptive changes due to disuse or early findings of reflex sympathetic dystrophy. An MRI of the foot that day showed minimal soft tissue edema in the dorsal lateral aspect of the forefoot and minimal soft tissue edema in the plantar aspect of the fifth digit; a minimal first metatarsal phalangeal joint effusion, minimal effusions of the second, third and fourth metatarsal phalangeal joints. Dr. saw the Patient on 09/22/06 and documented findings of the inability to fully weight bear on the right lower extremity, an antalgic gait on the right, pain with motion of the right ankle in all directions and with plantar and dorsal flexion, Achilles reflexes were 1 plus. There were specific areas of active and reproducible trigger point tenderness to the gluteus maximus and gluteus medius, hypersensitivity in the right lower extremity and coolness to the right foot. Complex regional pain syndrome of the right lower extremity per the history and physical and bone scan, neurological instability and low back and gluteal pain were diagnosed and labs, two lumbar sympathetic blocks under fluoroscopic imaging one week apart, Neurontin and a rehabilitation program were recommended. Dr. reviewed the case on 10/10/06 and did not agree with the

blocks due to the lack of evidence of reflex sympathetic dystrophy, the lack of a bone scan as well as the lack of conservative treatment.

The Patient received two sympathetic blocks prior to 11/02/06 with significant improvement of her pain for 4-5 days with decreased burning, sensitivity and an improved gait pattern. She had another lumbar sympathetic block on 11/29/06 with reported worsening of her symptoms. Dr. evaluated the Patient on 01/15/07 noting continued right foot and low back pain with numbness, pins, tingling, burning, weakness and hypersensitivity. A slow guarded limp on the left, mild tenderness to palpation at L4-5, tenderness to palpation of the right foot and ankle and coldness of the right foot, the inability to perform heel or toe walk and 4/5 strength of right ankle dorsiflexion and plantarflexion and hip flexors were noted on examination. She was deemed to have reached maximum medical improvement as of 10/01/06 with a 0 percent impairment rating for the low back injury.

Dr. evaluated the Patient on 01/30/07 for continued pain and discomfort of the right lower extremity. He noted improvement in the coldness with a right lumbar sympathetic block with phenol. An antalgic gait, pain with motion of the right ankle in all directions, coolness of the right foot, some slight cyanosis and hyperalgesia and hypersensitivity were noted. Continuation of the rehabilitation program, Lyrica, Advil and discontinuation of Neurontin were advised. The Patient continued treating with Dr. for neuropathic symptoms.

At the 05/08/07 visit the Patient reported the ability to walk and function better, but had continued hypersensitivity and dysesthesias. A functional capacity evaluation and lumbar sympathetic block with phenol under fluoro were recommended. Dr. stated that the Patient had the block approximately five months prior with significant improvement. On 05/21/07 the Patient reported a significant flare-up of symptoms following a functional capacity evaluation with discoloration to the dorsum of the right foot and toes and swelling. Cyanosis, an antalgic gait, hypersensitivity and pain with motion were noted. A trigger point injection with Toradol was administered and a functional capacity evaluation recommended a work conditioning program. She was awaiting a lumbar sympathetic block with phenol and work conditioning approvals. The requested block was denied on two reviews dated 05/23/07 and 05/30/07. On 06/05/07 the Patient presented with increased pain and difficulty with ambulation and weight bearing and more cyanosis to the foot and ankle. Slight cyanosis of the third through fifth digits of the right foot, pain with motion, an antalgic gait, hyperhidrosis and hypersensitivity were noted. Dr. again recommended a right lumbar sympathetic block with phenol under fluoro.

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

Official Disability Guidelines clearly support using both local anesthetics and neurolytic blocks for symptoms relief following the demonstration of sympathetically-maintained pain. Throughout this Patient's treatment, she has been at modified duty. MRI studies clearly support bone resorption indicative of early chronic regional pain syndrome pathology. Dr. notes show previous diagnostic lumbar sympathetic blocks with significant improvement in both symptoms and signs of pathology. Dr. notes show signs throughout of cold foot, edematous distal digits, cyanosis, antalgic gait and hyperhidrotic condition. The symptoms noted throughout include guarding to range of motion, allodynia, numbness and burning. There was a more recent flare up of the condition with the functional capacity evaluation performed. There was also documentation of lumbar Phenyl block in the past with improvement. The notes do not continually support linear improvement, which is not unusual for either this condition or for multiple observers when, in fact, many times physician assistants and other health care support people do the exam for the physician. Dr. also makes it clear that continued delay may result in a worse, long term outcome. It is the Reviewers experience that comments on aggressive physical therapy and failure to exhaust physical therapy are hard to accomplish in a patient that has reflex sympathetic dystrophy that limits even the Reviewer's ability to do an examination. Therefore, the request for neurolytic sympathetic block with phenol under fluoroscopic guidance is recommended as medically necessary.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES** Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, (i.e. Pain Chapter – Sympathetic Blocks for CRPS).
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**