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DATE OF REVIEW:
JUNE 15, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Are two lumbar sympathetic blocks with fluoroscopy and four to six trigger point injections medically necessary?

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

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
Left knee MRI, 01/03/07
EMG/NCS, 02/26/07
Bone scan, 02/27/07
Review, Dr. 03/05/07
Lower extremity evoked potential study, 03/10/07
Office note, Dr. 03/19/07
Therapy notes, 04/04/07, 04/18/07
Notes, 04/05/07, 04/19/07
Case note, 04/10/07
Review from radiology, 04/23/07

Office notes, Dr. 04/23/07 and 05/08/07
Review, Dr. 04/25/07
Letters, 04/30/07 and 05/15/07
Review, Dr. 05/14/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a left handed male pipe fitter who sustained a left lower extremity crush injury. While attempting to free his lower extremity he indicated he had to violently move and twist. He initially reported left leg pain and weakness with associated foot drop. MRI evaluation of the left knee performed on 01/03/07 noted a small Bakers cyst without evidence of internal derangement. Electrodiagnostic studies conducted on 02/26/07 identified a left peroneal nerve crush injury at the head of the fibula with significant weakness in the left dorsiflexors and great toe extensor, as well as radiculopathy involving the L4-S1 nerve roots. A bone scan evaluation of the bilateral knees completed on 02/27/07 indicated abnormal activity in the distal femur that could not exclude a bone bruise or non-displaced fracture. A peer review of the electrodiagnostic studies done on 03/05/07 felt the report represented a non-diagnostic study as it did not completely evaluate the peroneal nerve and it did not clearly define lumbar radiculopathy. Lower extremity evoked potential studies from 03/10/07 noted indication of bilateral L5, right L4 and S1, and left L3 sensory root involvement. Office evaluation by Dr. on 03/19/07 continued to report complaints of left leg pain as well as low back pain with spasm. The claimant was noted to be treating with Vicodin, Motrin, physical therapy and activity modification. Physical examination from a physical therapy note dated 04/04/07 demonstrated left knee range of motion from 0-125 degrees, 3+/5 extensor hallucis longus weakness, 4/5 quadriceps weakness, and 4+/5 dorsiflexion weakness; as well as lumbar tenderness, spasm and positive left straight leg raise for low back pain. On 04/05/07 he was placed on Neurontin with notation that he had normal sensation now. On 04/10/07 he was noted to be using a left knee brace with intermittent complaints of left calf, foot and toe numbness and low back pain. Physical therapy and medications were continued without notation of the specific medications utilized.

A radiology review was conducted on 04/23/07 that supported normal findings on the left knee MRI. The reviewer also felt the bone scan findings were relatively non-specific, would not have been seen on the left knee MRI and would require additional imaging if clinically indicated. The claimant was evaluated by Dr., pain management, on 04/23/07 with ongoing complaints of left knee pain radiating to the left foot and toes with associated coldness, numbness, tingling and edema to the left foot. There was reference to a prior CT study being done with no findings or report provided. There was reference to prior left ankle surgery in 1999 without the specifics provided and the claimant was noted to be a smoker. Physical examination demonstrated a pale left foot; left calf atrophy; antalgic gait; reproducible trigger points in the left hamstring, popliteus and gastroc; decreased sensation along the left peroneal nerve; and conflicting documentation indicating the lower extremity was warm and dry as well as documentation that the left lower extremity was slightly cool with edema and hypersensitivity. The claimant was diagnosed with mixed neuropathic and somatic pain; possible complex regional pain syndrome; myofascial pain syndrome to the left popliteus and left gastroc; and low back pain of unknown etiology with radiculopathy on

electrodiagnostic study. Recommendations were made for two lumbar sympathetic blocks and trigger point injections to the left lower extremity, as well as continued rehabilitation for desensitization, Celebrex and Lyrica.

A medical review was conducted on 04/25/07 with recommendation for denial of the requested injections. The reviewer felt there was no clear presentation of autonomic dysfunction in the records provided and that the request for sympathetic blocks was premature in light of the fact Dr. had only evaluated the claimant on one occasion. The reviewer also felt trigger point injections were not supported as the extent of conservative care was not provided. Dr. appealed the denial. Another medical review was done on 05/14/07 that also noted the electrodiagnostic studies were inconclusive, the clinical findings were inconsistent and there was no indication to threat myofascial trigger points as the injury occurred to the left lower extremity and not the lumbar spine. This reviewer upheld the prior denial. Physician discussion did not occur with either review.

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

This reviewer recommends denial of lumbar sympathetic blocks and/or trigger point injections. There is conflict within both the physical exam signs and symptoms and history of the claimant. There are also multiple sophisticated exams including MRIs and electrodiagnostic studies that are inconclusive. In addition, the reviewer's experience with chronic regional pain syndrome is that it is very difficult to do trigger point injections to sites involved with complex regional pain. Therefore clinical direction needs to be established before a treatment plan can be orchestrated. Therefore, after a careful review of all medical records, the reviewer's medical assessment is that the trigger point injections are not medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates; Pain- CRPS Sympathetic and Epidural Blocks, and Pain- Trigger Point Injections.

CRPS, Sympathetic and Epidural Blocks: Recommended when used for symptom relief and to demonstrate sympathetically maintained pain (SMP). (Stanton-Hicks, 2004) A systematic review revealed a paucity of published evidence supporting the use of local anesthetic sympathetic blocks for the treatment of CRPS. (Cepeda, 2005) Regional sympathetic blocks are used for (1) Upper extremity: Stellate ganglion blocks or laparoscopic blocks; or (2) Lower extremity: Lumbar sympathetic block. Signs of a successful block: Temperature rise to 35°; Sympathetic skin response using modified ECG; Cold pressor test; Laser Doppler flowmetry. This type of evaluation is important, especially if the block is unsuccessful in eliminating pain in order to determine if a complete block was performed. A sensory examination should also be completed in patients with pain relief. Local anesthetic can also result in somatic block that can affect pain. Pain relief may also be due to systemic uptake of local anesthetic or a placebo effect. (Grabow, 2005) Evaluating and treating results should include: (1) Complete elimination of pain: consider prolonged neurolytic block; consider the use of a α1 adrenoceptor blocker such as terazosin; & (2) Current suggested guidelines suggest that a maximum sustained benefit is obtained after 3 to 6 blocks when used in addition to PT. (Washington, 2002) (Stanton-Hicks, 2006) They also state that even if the original site is unresponsive, future exacerbations of CRPS at the same site or distant site may respond to 1 to 3 blocks. (Washington, 2002) Alternatives to regional sympathetic

blocks may be necessary when there is evidence of coagulopathy, systemic infection and/or post-surgical changes. These include peripheral nerve and plexus blocks and epidural administration of local anesthetics. Mixed conduction blocks (central neural blocks) are suggested when analgesia is insufficient by pharmacologic means to support physical therapy: (1) Implanted catheters at the brachial or lumbosacral plexus: allows for 1 to 2 weeks of therapy. Side effects include technical failure and infection; & (2) Epidural tunneled catheters: allows for long-term therapy: Side effects: same as above. Clonodine has also been effective epidurally. (Stanton-Hicks, 2006) Baclofen has been demonstrated to be effective intrathecally to reduce dystonia. (van Hilten, 2000) IV regional sympathetic blocks are controversial due to varying success. Guanethadine was used, but is no longer available in the US. Bretylium and reserpine require daily blocks, and have potential side effects of transient syncope with apnea, orthostatic hypotension, pain with administration, nausea and vomiting. Bretylium provided a 30% improvement in pain compared to placebo. Due to modest benefits and the invasiveness of the therapies, epidural Clonodine injection and intravenous regional sympathetic block with bretylium should be offered only after careful counseling, and they should be followed by intensive physical therapy. Intravenous regional sympathetic block (Bier's block, 25 sessions) with guanethidine and Lidocaine resulted in excellent pain relief and full restoration of both function and range of movement of the affected extremity in patients suffering from CRPS-I of the hand. (Paraskevas, 2005) Local or systemic parecoxib combined with Lidocaine/clonidine IV regional analgesia is an effective treatment for CRPS-I in a dominant upper limb. (Frade, 2005) See also Sympathetically maintained pain (SMP).

Trigger point injections: Recommended only for myofascial pain syndrome as indicated below. See Myofacial pain. Not recommended for radicular pain. A trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. (Graff-Radford, 2004) (Nelemans-Cochrane, 2002) See also the Low Back Chapter. For fibromyalgia syndrome, trigger point injections have not been proven effective. (Goldenberg, 2004)

Criteria for the use of Trigger point injections:

Trigger point injections with a local anesthetic with or without steroid may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met:

1) There should be documentation of circumscribed trigger points (including the specific muscle where located). There should be evidence upon palpation of a twitch response (evidence of a reflex contraction when mechanically irritated with modalities such as snapping palpation) as well as referred pain.

2) Symptoms have persisted for more than three months.

3) There is documentation that medical management therapies such as stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain

4) There should be evidence of an active program of therapy and stretching (which can be home based) at the time of the injections.

5) There should be evidence that the patient has been educated in self-management techniques of treating their trigger points.

6) Radiculopathy is not present (by exam, imaging, or neuro-testing).

7) Not more than 4 injections per session.
8) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement.
9) Frequency should not be at an interval less than two months.
10) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended.
(Colorado, 2002) (BlueCross BlueShield, 2004)

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**
- ☐ **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)**