

# **RYCO MedReview**

## **Notice of Independent Review Decision**

### **IRO REVIEWER REPORT – WC (Non-Network)**

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**DATE OF REVIEW:** 10/19/07 (AMENDED 10/24/07)

**IRO CASE #:**

#### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Lumbar sympathetic block

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

Board Certified in Orthopedic Surgery

#### **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.

Lumbar sympathetic block - Overturned

#### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Evaluations with M.D. dated 02/17/03, 02/24/03, 03/03/03, 11/10/03, 04/29/04, 07/06/04, 07/29/04, 09/02/04, 11/11/04, 12/09/04, 01/07/05, 03/08/05, 04/19/05, 07/12/05, 10/10/05, 04/18/06, 07/12/06, 08/09/06, 08/30/06, and 10/25/06

A prescription from Dr. dated 04/29/04  
Chest x-rays interpreted by M.D. dated 06/23/04  
A discharge summary from Dr. dated 07/09/04  
Evaluations with M.D. dated 07/09/04, 07/12/04, 07/13/04, 07/14/04, 08/05/04, 08/24/04, 07/31/06, 08/01/06, 08/02/06, 08/03/06, and 08/04/06  
X-rays of the left knee interpreted by M.D. dated 07/12/04  
A physical therapy evaluation with P.T. dated 11/16/04  
A Functional Capacity Evaluation (FCE) with B.S., P.T.A. dated 12/28/04  
A peer review from, M.D. dated 01/11/05  
PLN-11 forms from the insurance carrier dated 03/22/05, 07/19/05, and 07/24/07  
An MRI of the lumbar spine interpreted by M.D. dated 04/01/05  
An evaluation and EMG/NCV study interpreted by M.D. dated 04/13/05  
TWCC-73 forms from Dr. dated 04/19/05, 07/12/05, 10/10/05, 04/18/06, 07/12/06, 08/04/06, 08/30/06, 10/25/06, and 07/24/07  
A Required Medical Evaluation (RME) with M.D. dated 06/28/05  
A letter from Dr. dated 08/29/05  
Evaluations with M.D. dated 10/04/05, 02/28/06, and 09/26/06  
An addendum report from Dr. dated 10/27/05  
Procedure notes from Dr. dated 01/09/06, 01/23/06, and 02/09/06  
A psychological evaluation with Ph.D. dated 03/15/06  
An emergency room visit with M.D. dated 05/25/06  
Chest x-rays interpreted by M.D. dated 05/25/06  
An evaluation with M.D. dated 06/20/06  
Laboratory studies dated 07/17/06  
Chest x-rays interpreted by M.D. dated 07/17/06  
An operative report from Dr. dated 07/25/06  
A request form from Dr. dated 10/25/06  
Evaluations with M.D. dated 12/08/06, 03/28/07, 06/27/07, 07/24/07, 08/22/07, and 09/24/07  
A letter of adverse determination, according to the ODG, from L.P.N. dated 01/05/07  
A discharge summary from Dr. dated 02/05/07  
A letter of non-certification, according to the ODG, from D.O. dated 07/27/07  
A peer review from M.D. dated 08/07/07  
A reconsideration request from the patient dated 08/14/07  
A letter of non-certification, information other than the ODG, from M.D. at dated 08/22/07  
A letter of IRO request from at the Law Offices dated 10/05/07

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

Synvisc injections to the left knee were performed by Dr. on 02/17/03, 02/24/03, and 03/03/03. On 07/09/04, the patient was status post a left knee arthroplasty on 07/06/04 and was given Coumadin on 07/09/04. X-rays of the left knee interpreted by Dr. on 07/12/04 revealed good alignment of the arthroplasty with no loosening or infection. On 08/24/04, Dr. recommended aquatic therapy and a

home exercise program. An FCE with Mr. on 12/28/04 indicated the patient functioned at the sedentary physical demand level. An MRI of the lumbar spine interpreted by Dr. on 04/01/05 revealed a disc protrusion at L2-L3 and foraminal narrowing at L2 through S1. An EMG/NCV study interpreted by Dr. on 04/13/05 was unremarkable. On 07/19/05, a PLN-11 form from the insurance carrier indicated they denied the compensable injury extended to and included the lumbar spine. On 07/24/07, another PLN-11 form was filed and the insurance carrier disputed complex regional pain syndrome. On 10/04/05, Dr. recommended lumbar sympathetic blocks, physical therapy, and Neurontin. Lumbar sympathetic blocks were performed by Dr. on 01/09/06, 01/23/06, and 02/09/06. On 02/28/06, Dr. recommended a pain management program, Lyrica, and possible dorsal column stimulation. On 07/12/06, Dr. recommended another knee surgery. A repeat knee surgery was performed by Dr. on 07/25/06. On 09/26/06, Dr. recommended spinal cord stimulation, Lyrica, and Ultram. On 03/28/07 and 07/24/07, Dr. recommended continued Relafen, Baclofen, Lyrica, and lumbar sympathetic blocks. On 07/27/07, Dr. wrote a letter of non-certification for the lumbar sympathetic block. On 08/14/07, the patient wrote a reconsideration request for the lumbar sympathetic block. On 08/22/07, Dr. wrote a letter of non-certification for the lumbar sympathetic block. Ms. requested an IRO on 10/05/07.

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

I am unable to ascertain why the patient had a total knee replacement as a portion of the occupational injury. Unfortunately, this individual has a chronic regional pain syndrome after her partial total knee replacement and it was treated successfully with the sympathetic nerve block. Therefore, the patient clearly does have allodynia traits, consistent with a chronic regional pain syndrome. According to the ODG, the chapter on chronic pain, lumbar sympathetic blocks are indicated in the treatment of this type of complex regional pain syndrome. Therefore, in my opinion, based upon the ODG and my clinical experience, the request of for a lumbar sympathetic block is reasonable and necessary as related to the compensable injury.

**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)**