URAC ACCREDITED

CLAIMS EVAL

Utilization Review and Peer Review Services

DATE OF REVIEW: 12/08/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar sympathetic block under fluoroscopy with IV sedation on the right.

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

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

- DO., office visits from 01-23-03 through 11-14-08 (98 visits).
- DO., operative procedure reports from 9-10-02 through 9-17-08.
- 8-21-04, MD., performed a Required Medical Evaluation.
- 9-1-04 MD., addendum report.
- Emergency Room visits on 4-7-05, 5-18-05, 5-31-05, 6-23-05, and 7-27-05.
- 4-2-07, MD., performed a Designated Doctor Evaluation.
- 10-15-08 MD., performed a Utilization Review.
- 11-7-08 DO., performed an Appeal Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Medical records reflect a claimant with a date of injury of xx/xx/xx. The claimant developed pain in her hand and wrist while working at xxxx. She worked for them for approximately 13 years and then developed what was thought to be bilateral carpal tunnel syndrome. She underwent releases and multiple surgeries on the tendons and nerves of her arms and hands. By 1998, she had multiple surgeries, as many as 16 on her hands, wrists and forearms along with multiple blocks. She also underwent psychological and psychiatric care and pain management. The claimant was also seen by Dr. on 8-27-98, who did not recommend further surgeries. He noted that while she had a chronic pain syndrome with a history of RSD, he found nothing in his physical examination to support the diagnosis for RSD.

In spite of his consultation, the claimant underwent further surgeries, which failed. In 2000, the diagnosis of RSD of her legs and lumbar spine was made. She underwent series of lumbar sympathetic blocks. She was also provided with dorsal column stimulator, which provided partial relief.

On 9-10-02, the claimant underwent bilateral lumbar symptomatic blockade under fluoroscopy.

On 1-21-03, Dr. reports the claimant is seen for her myofascial pain complaints of her lumbar spine effectively treated with trigger point therapy. On 4-21-03, Dr. provided left and right paracervical and left and right lumbar trigger point injections.

On 5-13-03, Dr. reports the claimant is showing signs of degenerative arthritis in her knee. It was recommended she be evaluated by an orthopedist for this. The claimant

was also recommended pool therapy. It was noted the claimant was showing signs of RSD, swelling, sensitivity, and burning pain to her right leg. Sympathetic blockade may be advocated in the future.

Follow up visits noted the claimant continued with burning pain to the knee. She was continued with trigger point injections and medications, which included Neurontin 600 mg three times per day and 2 Norco three times per day. Follow-up visits noted the claimant continued with intractable nonmalignant pain syndrome. Exercise therapy was encouraged.

On 8-12-03, Dr. reported the claimant underwent a sympathetic block, which offered more than 70% pain relief for at least 4-5 days. Therefore, the claimant would like to complete the series. On 8-5-03 and 8-15-03, the claimant underwent bilateral lumbar sympathetic blockade.

On 9-9-03, the claimant underwent another lumbar sympathetic block with a diagnosis of complex regional pain syndrome of the lower extremities. Follow up visits noted the claimant continued with pain in her back at the area or the insertion site of the spinal stimulator. Injection to this area was recommended.

On 11-4-03, the claimant underwent myoneural infiltration in the area.

On 12-19-03, the claimant underwent replacement with Versatrel pulse generator.

Follow up visits noted the claimant was recovering from repositioning of her spinal cord stimulator battery, which was working well. On 1-16-04, it was noted the claimant had an apparent hematoma around her pulse generator site. She has running a low-grade temperature. The claimant was advised to go the hospital to be admitted for surgical evacuation of the hematoma, which was performed on 1-9-03. Follow up visits noted the claimant had scant staph aureus for which she was provided antibiotics.

The claimant continued to follow-up with Dr. The claimant felt that the battery was not working. The claimant underwent reprogramming. However, she continued with trigger point tenderness at the insertion site. The claimant was provided with trigger point injections.

Medical records reflect the claimant continued to follow up with Dr.. She was provided with medication refill. On 5-20-04, the claimant noted swelling in her foot and leg.

Follow up visits noted that the battery life of her stimulator had expired. Therefore, on 7-20-04, the claimant underwent replacement and implantation of Synergy battery. It was noted the claimant developed a superficial cellulitis, for which she was hospitalized and treated through 7-29-04.

On 8-21-04, MD., performed a Required Medical Evaluation. It was her opinion that the claimant was receiving maintenance care. The claimant was receiving treatment for the

complications post her stimulator placement. As for her condition of chronic pain syndrome, she did not believe that further testing was indicated. The claimant is on multitude of prescription medications along with the stimulator, which has not resulted in functional improvement or allowed this individual to return to work or remain employed. It was felt that the effects of the compensable injury had resolved some time ago. The claimant had no significant findings on clinical examination though she does have subjective complaints of low back pain. She has been treated for RSD/CRPS though the evaluator did not find clinical evidence of such. It was felt she had a diagnosis of chronic pain syndrome. She has been on SSI since 2001, therefore, it was not felt that she had the incentive at this point in time to return to work or seek any type of employment.

An addendum report provided by Dr. dated 9-1-04 noted that it was felt the claimant needed to complete her IV ABX course for her recent infection. It was felt the claimant had reached maximum therapeutic benefit in regards to her wrist and elbows. It was not felt that there was indication for further supervised therapies, medical care/treatments, diagnosis studies, prescription medications, pain management etc.

Medical records reflect the claimant continued to follow up with Dr. It was noted she was bilateral lower extremity swelling, causing her to walk with a cane. She had sensitivity to touch and burning pain as well. The claimant was continued with reprogramming of her stimulator and oral medications. On 1-18-04, the claimant underwent bilateral sympathetic block. The claimant reported 60% pain relief with the blockade. The claimant underwent a second blockade, which provided 50-60% pain relief.

Medical records reflect the claimant's subcostal wound was grossly infected. She had been to the emergency room and had been provided with Amoxicillin and Doxycycline for MRSA. Arrangements were made for right subcostal pulse generator removal, which was performed on 6-3-05.

On 10-17-05, Dr. noted the claimant is not receiving at least 50% relief of pain with her spinal cord stimulating device. It is not relieving her bilateral lower extremity pain. Therefore, it was not felt that replacement of the battery was worthy. On 11-15-05, the claimant underwent removal of existing electrode and removal of extension.

The claimant continued to follow-up with Dr. with complaints of leg pain. Dr. reported on 12-18-06, the claimant was provided with sympathetic blocks when she has an exacerbation of pain. Therefore, a series of three is recommended.

On 4-2-07, the claimant underwent a Designated Doctor Evaluation under the direction of, MD. It was his opinion the claimant was severely limited with a neurologic problem that is probably some form of CRPS that is related to the multiple surgeries that she has had for the original injury starting with carpal tunnel release. It was his opinion that the combination of the multitude of surgeries for her original injury had resulted in a complex regional pain syndrome, which is involving both the upper and lower

extremities at this time. He felt her disability was a direct result of the work related injury.

On 4-18-07, the claimant underwent a stellate ganglion block, which provided 70% pain relief. The claimant was continued with rehabilitation. It was noted the claimant was going for neck surgery in the near future.

On 5-10-07, the claimant underwent another stellate ganglion block.

Follow up visits noted the claimant was continued with her medications, which included Zanaflex, Neurontin, MS Contin and Norco. The claimant reported continued pain in her arms and hands and hypersensitivity. Follow-up visits noted that Trazadone was added to her regimen. On 10-8-07, the claimant underwent reprogramming of the Advanced Bionics stimulator. She reported excellent back, buttock and leg coverage.

Follow-up visits noted the claimant continued with her spinal cord stimulator receiving 70-80% improvement of her pain.

On 9-25-07, the claimant underwent implantation of dual Octrode advanced Bionics electrodes. The claimant continued to report 70% improvement of her pain. On 2-1-08, it is noted the claimant was eagerly waiting to go ahead with removal of her spinal cord stimulator of her cervical spine. This has helped her but at this point, she want to move on with less use of medications and procedures.

On 2-5-08, the claimant underwent removal of a cervical spinal cord stimulator electrode, lead and pulse generator battery.

Follow up visits noted the claimant was doing well with a combination of a weak narcotic analgesic, neuropathic and anti-depressant support. She was noted to have trigger point in the lower lumbar areas and in her neck, for which she underwent trigger point injections on 3-14-08. On 4-17-08, the claimant underwent additional trigger point injections due to the myofascial pain complaints of her left and right neck areas.

Medical records reflect an exacerbation of her symptoms and on 9-17-08, the claimant underwent right lumbar sympathetic blockade under fluoroscopy. Follow up visits noted near complete resolution of her right leg pain for two days. She has been able to take less than half her normal Norco medication. She has been able to turn off her stimulator. She was bright and cheerful.

On 10-15-08, a Utilization Review performed by MD., reflects a non-certification for lumbar sympathetic block under fluoroscopy. ODG guidelines used as supportive documentation.

On 11-7-08, an Appeal Non-certification was provided by DO., for lumbar sympathetic block under fluoroscopy. The evaluator reported that the documentation was confusing. It indicates that the claimant had improvement with the last sympathetic block that she

was able to turn off her stimulator. If the claimant has SCS it is unclear why the claimant needs sympathetic block as opposed to adjusting the parameters of the stimulator.

On 11-14-08, the claimant was seen for a follow-up with Dr.. He noted that the dynamic process of this disease waxes and wanes in intensity and frequency of complaints. The claimant recently had an exacerbation of her right leg. It was grossly edematous. While the spinal cord stimulator is offering her salutary benefit, it certainly does not help with the edema and intensification of her pain complaint. It is for that reason he was recommended right lumbar sympathetic blockade to help her with swelling, sensitivity and burning pain. It was recommended as it has helped her in the past. She is continuing on a combination of neuropathic, weak narcotic and anti-depressant support. This will be scheduled pending insurance authorization.

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

Based on the medical records provided, the request for lumbar sympathetic block is not evident. Lumbar sympathetic blockade is for more acute case of RSD to decrease pain and improve function. ODG-TWC reports that sympathetic blocks have a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. There is no evidence to support the medical necessity of an injury that is over a decade old plus if the blockade works then the next usual protocol is SCS which patient already has.

ODG-TWC, last update 12-3-08 Pain Chapter regarding Sympathetic blocks: Recommended as indicated below. Useful for diagnosis and treatment of pain of the pelvis and lower extremity secondary to CRPS-I and II. This block is commonly used for differential diagnosis and is the preferred treatment of sympathetic pain involving the lower extremity. For diagnostic testing, use three blocks over a 3-14 day period. For a positive response, pain relief should be 50% or greater for the duration of the local anesthetic and pain relief should be associated with functional improvement. Should be followed by intensive physical therapy. (Colorado, 2002)

ODG-TWC, last update 12-3-08 Pain Chapter regarding CRPS, sympathetic and epidural blocks: Recommended only as indicated below, for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. Detailed information about stellate ganglion blocks, thoracic sympathetic blocks, and lumbar sympathetic blocks is found in Regional sympathetic blocks. Recommendations for the use of sympathetic blocks are listed below. They are recommended for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. It should be noted that sympathetic blocks are not specific for CRPS. See Sympathetically maintained pain (SMP). 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 CRPS and usefulness remains controversial. Less than 1/3 of patients with CRPS are likely to respond to sympathetic blockade. No controlled trials have shown any significant benefit from sympathetic blockade. (Varrassi, 2006) (Cepeda, 2005) (Hartrick, 2004) (Grabow, 2005) (Cepeda, 2002) (Forouzanfar, 2002) (Sharma, 2006) *Predictors of poor response:* Long duration of symptoms prior to intervention; Elevated anxiety levels; Poor coping skills; Litigation. (Hartrick, 2004) (Nelson, 2006) *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*): 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. *Clonidine* 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*: 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 more than 30% pain relief for a mean of 20 days compared to placebo. (Hord, 1992) Due to modest benefits and the invasiveness of the therapies, epidural clonidine 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) 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); & Regional sympathetic 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 3 to 6 blocks. These blocks are generally given in fairly quick succession in the first two weeks of treatment with tapering to once a week. Continuing treatment longer than 2 to 3 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 allodynia) in physical therapy/occupational therapy. (4) There should be evidence that physical or occupational therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase. (5) In acute exacerbations, 1 to 3 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. (Burton, 2006) (Stanton-

Hicks, 2004) (Stanton-Hicks, 2006) (International Research Foundation for RSD/CRPS, 2003) (Colorado, 2006) (Washington, 2002) (Rho, 2002)

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)**