

RYCO MedReview

Notice of Independent Review Decision

DATE OF REVIEW: 01/28/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy three times a week for two weeks followed by twice a week for two weeks to be done in conjunction with lumbar sympathetic block

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

Board Certified in Anesthesiology
Fellowship Trained In Pain Management
Added Qualifications in Pain Medicine

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.

Physical therapy three times a week for two weeks followed by twice a week for two weeks to be done in conjunction with lumbar sympathetic block - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A TWCC-1 form dated 11/01/05
An emergency room report from, M.D. dated 11/01/05
A nursing note from an unknown nurse (signature was illegible) dated 11/01/05
X-rays of the right ankle and leg interpreted by, M.D. dated 11/01/05
Evaluations with, M.D. dated 11/02/05, 11/12/05, 11/30/05, 12/21/05, 01/04/06, 02/08/06, 03/08/06, 04/10/06, 05/12/06, 06/09/06, 07/18/06, 07/26/06, 09/08/06, 10/06/06, 10/27/06, 12/08/06, 02/09/07, 03/09/07, and 09/07/07
DWC-73 forms from Dr. dated 11/02/05, 12/21/05, 01/04/06, 04/10/06, 05/05/06, 06/09/06, 09/08/06, 10/06/06, 10/27/06, 12/08/06, 02/08/07, and 03/09/07
An associate statement from the patient dated 11/02/05
A physical therapy evaluation with an unknown therapist (signature was illegible) dated 11/05/05
Operative reports from Dr. dated 11/10/05 and 07/18/06
X-rays of the right ankle interpreted by, M.D. dated 11/10/05
A postoperative plan from Dr. dated 11/10/05 and 11/11/05
A physical therapy evaluation with, P.T. dated 11/11/05
Physical therapy with, P.T. dated 11/12/05 and 11/13/05
An emergency medical services report dated 11/16/05
A skilled nursing note from an unknown provider (no name or signature was available) dated 11/18/05
Physical therapy progress notes from an unknown therapist (signature was illegible) dated 11/20/05 and 12/02/05
A physical therapy evaluation with the same unknown therapist dated 11/27/05
Evaluations with, M.S.N., R.N. dated 04/03/06, 07/05/06, 08/03/06, 09/29/06, 10/16/06, 07/23/07, 08/28/07, 09/17/07, and 10/08/07
Occupational therapy with, O.T.R. dated 05/05/06, 05/09/06, 05/10/06, 05/11/06, 05/22/06, 05/22/06, 08/18/06, 08/23/06, 08/30/06, 09/05/06, and 09/06/06
Evaluations with, M.D. dated 05/08/06, 05/26/06, 08/07/06, 09/11/06, 11/15/06, 02/12/07, 04/09/07, 06/04/07, 08/13/07, 09/28/07, and 01/04/08
X-rays of the chest interpreted by, M.D. dated 07/14/06
An impairment rating evaluation with, D.C. dated 02/16/07
A three phase bone scan interpreted by, D.O. dated 08/23/07
An operative report from Dr. dated 09/28/07
An evaluation with, P.T. dated 10/19/07
A preauthorization request form from Dr. dated 11/12/07
An evaluation with (no credentials were listed) dated 11/12/07
An appeal request from Dr. dated 11/21/07
A letter of adverse determination, according to the ODG, from, M.D. dated 11/27/07
A letter of adverse determination, according to the ODG, from, M.D. dated 12/12/07
A phone note from Dr. dated 12/12/07
A letter from at Pain Recovery dated 12/18/07
A preauthorization request form from dated 01/03/08
An IRO summary dated 01/08/08

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

The Employer's First Report of Injury or Illness form stated the patient slipped and fell and fractured her ankle on xx/xx/xx. X-rays of the right ankle interpreted by Dr. on 11/01/05 revealed a trimalleolar fracture at the ankle. Right ankle surgery was performed by Dr. on 11/10/05. On 11/30/05, Dr. placed the patient in an ankle brace. Occupational therapy was performed with Ms. from 05/05/06 through 09/06/06 for a total of 11 sessions. On 05/08/06, Dr. prescribed Celebrex. On 07/18/06, Dr. removed the hardware of the right tibia and fibula. On 08/07/06, Dr. recommended physical therapy three times a week for four weeks. On 09/29/06, Ms. recommended Norco, Paxil, Flexeril, Lidoderm, and Ketoprofen. On 02/16/07, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 4% whole person impairment rating. A bone scan of the right foot interpreted by Dr. on 08/23/07 revealed non-specific uptake in the right foot. On 09/07/07, Dr. recommended an evaluation with a foot and ankle specialist. On 09/28/07, Dr. performed a lumbar sympathetic block at L2 and L4 on the right. On 10/08/07, Ms. recommended Norco, Paxil, Lidoderm, Naproxen, Flexeril, and physical therapy. On 11/12/07, Dr. wrote a preauthorization request for physical therapy. On 11/21/07, Dr. provided a letter of appeal for physical therapy. On 11/27/07, Dr. wrote a letter of adverse determination for the physical therapy. On 12/12/07, Dr. also wrote a letter of adverse determination for the physical therapy. On 01/04/08, Dr. recommended continued home exercises, Naprosyn, Norco, and a possible repeat sympathetic block.

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

This patient has never had sufficient physical examination evidence nor subjective complaints to substantiate a diagnosis of chronic regional pain syndrome. Initially, the patient did not have a sufficient response to initial lumbar sympathetic block to confirm the diagnosis nor did the bone scan demonstrate findings consistent with that condition. Therefore, the diagnosis of chronic regional pain syndrome, in my opinion, is neither correct nor supported by the clinical evidence presented for review. Therefore, neither the lumbar sympathetic block nor further supervised physical therapy is medically reasonable or necessary. This patient has had more than 20 sessions of supervised physical therapy thus far, as is said to be doing her home exercises regularly. She is also said to be fully capable of full duty work, and, according to the last progress note, has no significant physical examination findings nor does she complain of significant pain levels. Specifically, the most recent physical examination did not include any of the cardinal physical signs of chronic regional pain syndrome, thereby excluding the presence of that condition as a valid current diagnosis. There is no medical reason or necessity, therefore, for the

patient to be referred for supervised physical therapy three times a week for two weeks, followed by twice a week for two weeks to be done in conjunction with a lumbar sympathetic block. This opinion is based on ODG treatment guidelines as well as clinical experience of 20 years in treating chronic regional pain syndrome and RSD.

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)