

# P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

**DATE OF REVIEW:** 06/20/2008

**IRO CASE #:**

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

This case was reviewed by a Pain Management, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

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

Left lumbar sympathetic blocks under fluoroscopic IV sedation

## **REVIEW OUTCOME**

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

Upheld (Agree)

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

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o July 23, 2007 Follow-up note from Dr.
- o July 30, 2007 Follow-up note from Dr.
- o August 23, 2007 Procedure report, sympathetic block from Dr.
- o August 31, 2007 Follow-up report from Dr.
- o September 13, 2007 Procedure report, sympathetic block from Dr.
- o October 15, 2007 Procedure report from Dr.
- o November 1, 2007 Follow-up report from Dr.
- o November 30, 2007 Follow-up report from Dr.
- o December 21, 2007 Follow-up note from Dr.
- o January 21, 2008 Follow-up report from Dr.
- o January 31, 2008 Follow-up note from Dr.
- o February 29, 2008 Follow up report from Dr.
- o March 11, 2008 Operative report, placement of a spinal cord stimulator from Dr.
- o March 14, 2008 Follow-up note from Dr.
- o March 27, 2008 Follow-up note from Dr.
- o May 1, 2008 Follow-up note from Dr. with ODG CRPS references
- o May 8, 2008 Letter of adverse determination
- o May 14, 2008 Follow-up note from Dr.
- o May 29, 2008 Note of verbal notification to requestor from, LVN
- o May 29, 2008 Letter of adverse determination for reconsideration request
- o June 2, 2008 Letter of Utilization Review findings from, LVN
- o June 2, 2008 Request for reconsideration
- o June 6, 2008 Request for IRO
- o June 11, 2008 Letter from summarizing the case

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

According to the records provided for my review, the patient is a -year-old employee who sustained an industrial injury to the

head, back, upper and lower extremities on xx/xx/xx. The patient has a failed lumbar surgery and the diagnosis included post-laminectomy pain syndrome. The injuries and sequella of the failed surgery have resulted in mental difficulties and complex regional pain syndrome (CRPD) in both the upper and lower extremities.

On July 23, 2007 the provider noted the patient was walking with antalgic limp and gait. The patient's medications include Lyrica, MS Contin, Cymbalta, Klonopin and Provigil. On examination, moderate swelling, hyperesthesia and allodynia was described in the patient's legs consistent with disseminated CRPS. Recommendation was for bilateral sympathetic blocks.

The patient returned on July 30, 2007. The patient has memory and mental deficits which make it difficult for him to understand the treatment. The disease process for CRPS and the role of sympathetic blocks was explained. No examination findings are noted.

Bilateral lumbar sympathetic blocks were provided on August 23, 2007 at L2.

At follow-up on August 31, 2007 a second lumbar sympathetic block was planned "to see if we can build upon the benefit gained from the first block. His pain continues to be 6-7/10 in his feet and lower extremities. He has some mild hyperesthesia. Spinal cord stimulation will be reserved for recalcitrant pain."

On September 13, 2007 a second sympathetic block was administered for bilateral feet pain associated with CRPS that ascends into his lower extremities.

At follow-up on October 15, 2007 the patient remains confused and psychological and behavioral modalities are considered. "His leg and burning pain continues. We are going to recommend sympathetic blockage."

On November 1, 2007 it is reported that the patient has failed interventional and medical treatment options. The patient is requesting spinal cord stimulation which he has hears about from other patients. A spinal cord stimulator could possibly provide 70% relieve and help his function and will be requested.

On November 30, 2007 it is noted that the patient continues with persistent and involuntary spasms in his foot and leg. He continues with narcotic medications and a spinal cord implant is desired. However, on December 21, 2007 it is noted that, per the patient's psychologist, additional psychological treatment is need prior to implantation of a spinal stimulator.

On January 31, 2008 the patient's pain level is noted to be 8-9/10 despite utilizations of maximum medications. Based on the trial of a spinal cord stimulator, either implantation of a stimulator or a Morphine pain pump will be recommended.

Global skin rashes, breakdown and erythematous changes consistent with skin manifestations of CRPS were noted on February 29, 2008. The patient is reported to have some numbness and swelling in the upper extremities and occasionally drops things.

A temporary spinal cord stimulator was placed under anesthesia on March 11, 2008. On March 14, 2008 it was apparent that the patient did not fit the criteria for implantation and the focus returned to oral medication management. On March 27, 2008 it was noted that the patient has difficulty keeping track of medications and dosages. Sympathetic blocks would be considered in the future.

On May 1, 2008 the patient continue with spasms in his leg, face and left arm. Sympathetic blocks were recommended as the standard treatment.

Request for sympathetic blocks was not certified in review on May 8, 2008 with rationale that the 5 pages of clinical notes and administrative records submitted with the request failed to include the surgical history that lead to the condition of CRPS, the results of diagnostic imaging or a history of lower levels of care. The medical records also failed to clarify whether to requested blocks were for diagnostic or therapeutic purposes or if the CRPS reported represented some form of peripheral neuropathy. A peer to peer discussion was attempted but not realized.

On May 14, 2008 the provider noted that the patient's symptoms are quite consistent with stage II CRPS as a direct result of his post lumbar laminectomy pain syndrome. The procedures are the standard of care. He does not have peripheral neuropathy. The diagnosis is inherited from a prior provider, who is a fellowship trained, board certified pain specialist. Reconsideration for sympathetic blocks was requested.

Request for reconsideration for sympathetic blocks was not certified in review on May 29, 2008 with rationale that the medical records, while reporting failure of a spinal cord trial, failed to document the patient's response to previous sympathetic blocks. The medical records failed to document exhaustion of physical therapy. In addition, the claimant did not meet all the criteria for definition of CRPS per the cited literature, which is continuing pain, allodynia, or hyperalgesia, evidence at some time of edema, changes in skin blood flow or abnormal sudomotor activity in the region of the pain.

Additional information was submitted by the clinician but it was determined on June 2, 2008 that a substantial change in the patient's medical condition had not taken place as required by rule 134.600 (0) (4) to warrant further consideration. On June 6,

2008 the provider requested an IRO.

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

At follow-up for the initial sympathetic block on August 31, 2007 it was noted that the patient continues with pain of 6-7/10 in his feet and lower extremities. He has some mild hyperesthesia. Spinal cord stimulation will be reserved for recalcitrant pain. Following the second sympathetic block of September 13, 2007 it was noted on October 15, 2007 that the patient's leg and burning pain continues. Additional blocks were considered.

As no improvements were documented, the reports indicate that the patient received little if any benefit from the first 2 sympathetic blocks. The treatment plan appropriately was modified to a trial of a spinal cord stimulator. A Morphine pump was also considered depending on the results of the stimulator trial. The trial for a stimulator implant failed. Return to sympathetic blocks which have been tried but not quantitatively reported as beneficial is not supported by the cited guidelines which require criteria of: Temperature rise to 35°; Sympathetic skin response using modified ECG; Cold pressor test; and 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. The medical records fail to document the signs of a successful block such as pain levels prior and post block, skin temperature readings, sympathetic skin response and vascular flow improvements with prior attempts and do not, therefore, substantiate a medical necessity for additional sympathetic blocks. Therefore, my recommendation is to agree with the previous non-certification of the request for left lumbar sympathetic blocks under fluoroscopic IV sedation.

The IRO's decision is consistent with the following guidelines:

**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

## The Official Disability Guidelines - Chronic Pain - Sympathetic Blocks - 6-17-08:

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  $\alpha_1$  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. 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 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 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, 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).