

DATE OF REVIEW: 6/26/2009
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient diagnostic lumbar sympathetic block with fluoro as related to the left ankle

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from and completed training in Anesthesiology at. He also completed a Fellowship in Pain Management from the. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Anesthesiology since 10/13/1995.

REVIEW OUTCOME:

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

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> Partially Overturned	(Agree in part/Disagree in part)

Outpatient diagnostic lumbar sympathetic block with fluoro as related to the left ankle Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a injured employee who tripped and sustained a severe inversion injury to her left ankle at work on xx-xx-xx. Following this accident she had an onset of pain and swelling in her left ankle. She is status post arthroscopy with synovectomy and excision of fracture fragment and anterior talofibular ligament repair on 11/14/2008.

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

The injured employee suffers from pain in the left ankle and knee. The injured employee's pain level ranges between 6-9/10. An MRI dated 7-14-08 showed there are small 3mm planter and posterior calcaneal spurs. Also, there is evidence of small tibiotalar and subtalar joint effusions. There is evidence of accessory muscle medial to flexor hallucis muscle. The soft tissue and osseous structures appear within normal limits. The injured employee's pain becomes worse by walking and sitting. She has used TENS and Biofreeze. On 11-14-08 she underwent a left ankle scope, left Brostrom anterior talofibular ligament repair, application of pain pump, application of posterior splint. The injured employee underwent PT in February and March 2009 which provided relief. The injured employee's medications include synthroid, prevacid, Zoloft, lorazepam, and trazadone.

There is only one note dated on xx-xx-xx that might support complex mediated pain syndrome. Per Dr. there is a physical exam that states the injured employee has Allodynia, hyperalgesia, and swelling. There are no other notes that support these physical findings. A note per Dr. on 3-5-09 indicated she had a physical exam with no swelling. The contradiction in notes needs to be clarified before a lumbar sympathetic injection is done. The injured employee does not meet the definition of RSD per Essentials of Pain Medicine and Regional Anesthesia, second edition, 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. These criteria must be satisfied to be considered CRPS (Complex Regional Pain Syndromes) 1 or 11 also known as RSD. Without confirming these signs and symptoms, a lumbar sympathetic block is not medically necessary. Therefore, the previous denial is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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

X 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

X PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)