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DATE OF REVIEW: 05/09/09

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 (Board Certified), 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

Cervical epidural blockage

REVIEW OUTCOME

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

(Overturned) (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o 180 pages of submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o April 2, 2007 RME Orthopedic review of records report from Dr.
- o May 24, 2007 Hand radiographic report interpreted by Dr.
- o June 13, 2007 Initial chiropractic examination from Dr.
- o June 14, 2007 SOAP notes, unsigned, from Integra
- o August 15, 2007 Worker's Compensation Associate statement from the employee
- o August 15, 2007 Employers First Report of Injury (hand hit against an object)---
- o September 12, 2007 RME Orthopedic review of records report from Dr.
- o November 17, 2007 DDE rpt from Dr. (unremarkable exam)
- o February 22, 2008 Psyche Consultation report from Dr.
- o April 21, 2008 Medical report, Integra - unsigned
- o May 20, 2008 Medical report, Integra - unsigned
- o May 23, 2008 Medical reports, Integra - unsigned
- o June 4, 2008 Medical report, Integra - unsigned
- o June 6, 2008 Medical report, Integra - unsigned
- o July 18, 2008 Medical report, Integra - unsigned
- o July 18, 2008 Psyche report from Dr.
- o July 28, 2008 MRI right hand interpreted by Dr.
- o August 1, 2008 Medical report, Integra - unsigned
- o August 14, 2008 Medical report, Integra - unsigned
- o August 15, 2008 Psyche medical report from Dr.
- o August 22, 2008 Psyche medical report from Dr. (recommend CPM x 20)
- o September 5, 2008 Medical report, Integra - unsigned
- o September 18, 2008 Unsigned medical report
- o October 10, 2008 Psyche medical report from Dr.
- o November 6, 2008 Initial Pain Management report from Dr.

- o December 19, 2008 Psyche medical report from Dr.
- o February 19, 2009 Adverse determination review for cervical epidural steroid injection from
- o February 20, 2009 Psyche medical report from Dr.
- o February 26, 2009 Follow-up medical notes from Dr.
- o February 26, 2008 SOAP notes from Dr
- o February 27, 2009 Psychological assessment,
- o March 2, 2009 Pre-Authorization request from Dr,
- o March 3, 2009 Pre-Authorization form from Dr..
- o March 9, 2009 Adverse determination review for ESI/Stellate ganglion block from
- o March 20, 2009 Psych medical report from Dr
- o March 20, 2009 Medical report, Integra - unsigned
- o April 28, 2009 Request for IRO
- o April 30, 2009 Assignment of IRO
- o May 4, 2009 IRO Organization Summary

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records submitted for review, the patient is a employee who sustained an industrial injury to the right arm and hand on xx-xx-xx (tendonitis/trigger finger) and again on xx-xx-xx (right upper extremity complaints reported 10 months after the onset of the compensable diagnosis). She is reportedly status post two surgeries, right thumb and index finger trigger release on September 29, 2006 and a second non-clarified surgery and is followed with pain management. The patient's current injury is reported as an injury to the right hand which occurred when the patient struck her hand against an iron bar on xx-xx-xx.

Right hand x-rays taken were interpreted as showing no radiographic evidence of acute bony trauma.

The medical report of June 14, 2007 indicates the patient is status post right carpal tunnel release and struck her hand on a bar at work. She saw a hand specialist who noted swelling. This is documented as a new injury. The diagnosis is contusion of the hand.

The patient underwent a Designated Doctor Examination on November 17, 2007. The patient had prior surgery to her right hand on 9/2006 and 3/2007. She was completely recovered when she struck her hand on a bar on May 23, 2007. The hand specialist noted tenderness at the 4th and 5th MP joints. She had physical therapy under a chiropractor. She reports steady but slow improvement. She is working light duty. No sensory or motor nerve damage was noted on examination. She is MMI as of November 13, 2007 with no impairment.

A psychological consultation was provided on February 22, 2008. Her hand contusion is resolving. Eight sessions of psychotherapy were recommended.

An unsigned medical report of April 21, 2008 notes tenderness, palpatory guarding and muscle inflammation in the right hand. Weakness, not further clarified, is noted. The patient feels she is worsening. On May 20, 2008 the patient reports sleeping difficulty and depression secondary to pain. The report is not signed. An unsigned medical report of May 23, 2008 indicates the patient is anticipating a surgery, not further clarified.

Per an unsigned medical report of July 18, 2008 the patient can no longer flatten out her hand due to decreased range of motion and pain. A cyst is noted on the extensor tendon of the 4th digit, on the dorsum of the right hand. The patient is using Lunesta, Norco and Pristiq. A psyche consultation of the same date notes the patient has suffered significant relationship hardships secondary to her injury to the right ring and small finger.

Right hand MRI was performed on July 28, 2008 and provided an impression of, normal non-contrast MRI of the right hand. Patient motion artifact is evident on multiple sequences. If clinically indicated, the patient should return for examination utilizing sedation.

An unsigned medical report of August 1, 2008 indicates the patient has complaints of sharp pain, swelling, stiffness, soreness, muscle aches, limited motion, burning and muscle weakness. She saw a hand specialist who recommended hot packs/ice, ultrasound and 8 sessions of massage. She does not think therapy will be helpful. We will try the treatment and if the hand specialist still does not think she is surgical we will send her for a pain management consultation.

The patient underwent a functional capacity evaluation on August 14, 2008. The patient appears to have a sedentary demand level capability.

The psyche evaluation report of August 22, 2008 indicates the patient will stop medication of Pristiq and initiate W ellbutrin XL 150 mg. Impression is injury to the ring finger and the small finger on the right and chronic pain disorder associated with physical and psychological factors.

An unsigned medical report of September 5, 2008 notes the patient's psyche provider is adding Cymbalta to her medications.

An unsigned medical report of September 18, 2008 indicates the patient is recommended a steroid injection for right elbow

tenderness over the right later epicondyle.

The patient was evaluated in pain management on November 6, 2008 for chronic, persisting right arm and hand pain, swelling sensitivity, and throbbing pain which the patient describes as 7/10. Per testing she also demonstrates moderate to severe reactive depression and anxiety related to her chronic pain. She is using Lunesta, Celebrex and hydrocodone. She is 5' 3" and 290 pounds (BMI 53.03). There is swelling about the right wrist, arm and hand. Her right hand is moist to touch bilaterally. There is a mottled skin appearance in the palmar aspects of the right hand and marked hyperesthesia and allodynia throughout the right upper extremity extending into the neck, shoulder and upper back. Her diagnosis is CRPS of the right arm and hand extending into the central neuraxis following a work-related injury and subsequent surgical intervention, secondary myofascial pain syndrome of the neck and upper back areas and moderate to severe reactive depression and anxiety in a non-smoker with chronic pain syndrome. Treatment will include Lyrica, Cymbalta and sympathetic blockage.

Request for cervical epidural steroid injection was not certified in review on February 19, 2009 with rationale that a steroid injection is not medically reasonable for the accepted diagnosis of hand contusion. It is only indicated for cervical radiculopathy when objective signs of radiculopathy are documented. A peer discussion was attempted but not realized.

The psyche reevaluation of February 20, 2009 notes examination findings of guarded movement of the dorsal wrist on the right with noticeable swelling. Wrist muscle strength is weak. Recommendation is for 20 sessions of chronic pain management for chronic pain.

An unsigned medical report of February 26, 2009 notes objective findings of tenderness, weakness, muscle inflammation, muscle spasms and regionally decreased range of motion.

Per a pain management follow-up note of February 26, 2009 the patient is being treated for her right arm and hand complaints associated with reactive depression and neuropathic pain. She is exercising. Her arm is less swollen and hyperesthetic. Recommendation is for central neural blockade for her right arm and hand complaint in the form of cervical epidural blockade. This has been denied once, thinking we are treating her neck. We are not treating her neck. We are treating her arm and hand pain, hyperesthesia and allodynia.

The patient was assessed by a social worker on February 27, 2009 and was recommended for participation in a chronic pain management program.

Request for reconsideration of ESI/stellate block was not certified in review on March 9, 2009 with rationale that the medical records fail to substantiate a diagnosis of CRPS. The occupational injury is limited to a hand contusion. The request for ESI/stellate block does not meet ODG criteria. A peer discussion was attempted but not realized.

A psyche reevaluation report of March 20, 2009 indicates the patient will continue medications of Cymbalta 60 mg, Trazodone 100 mg, Norco 10 mg three times daily, Lyrica 100 mg three times daily and Klonopion 1 mg.

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

The patient has a historical diagnosis of contusion to the hand and mood factors.

The patient was evaluated by pain management on November 6, 2008 for chronic, persisting right arm and hand pain, swelling sensitivity, and throbbing. Physical examination notes swelling about the right wrist, arm and hand. Her right hand is moist to touch bilaterally. There is a mottled skin appearance in the palmar aspects of the right hand and marked hyperesthesia and allodynia throughout the right upper extremity extending into the neck, shoulder and upper back. Her diagnosis is CRPS of the right arm and hand extending into the central neuraxis following a work-related injury.

Recommendation has been for central neural blockade for her right arm and hand complaints in the form of a cervical epidural blockade. This would effectively block the preganglionic sympathetic fibers, acting in effect like a sympathetic block in this case.

Sympathetic blocks are indicated, per ODG, for a diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. Predictors of poor response: Long duration of symptoms prior to intervention; Elevated anxiety levels; Poor coping skills; Litigation.

Given the high suspicion of CRPS noted by the pain management specialist, my determination is to overturn the previous non-certification of the request for cervical epidural blockade, and certify this request.

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
- 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
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

ODG - Pain Chapter - CRPS, Sympathetic and Epidural Blocks - (4-30-2009):

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)