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## Notice of Independent Review Decision

**DATE OF REVIEW:** 1/21/10

**IRO CASE #:**

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

Bilateral lumbar sympathetic block under fluoroscopy with IV sedation

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

Certified by the American Board of Anesthesiology, with subspecialty certification in Pain Medicine

### **REVIEW OUTCOME**

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

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	337.20	6450	Upheld

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

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician notes dated 12/9/09, addendum note dated 11/17/09, 11/5/09, 10/19/09, 8/31/09, 8/10/09

Operative report dated 9/23/09

Official Disability Guidelines cited – Chapter Pain Regional sympathetic blocks

### **PATIENT CLINICAL HISTORY:**

The patient is a female who is reported to have sustained work related injuries on xx/xx/xx. The first available clinical record is dated 08/10/09. It is reported that the patient presents with gross edema and a cellulitic condition of her left foot and leg and as such, a series of sympathetic blocks have not been completed. The patient is reported to have lost 5 pounds of fluid weight associated with RSD following previous sympathetic blockade. As a result of her cellulitis, her pain has increased. Her dysfunction has increased. She is reported to have moderate swelling, hyperesthesia and allodynia throughout both lower extremities. She is taking a combination of anti-depressant and neuropathic pain support as well as Benzodiazepines at night to help her with sleep. Her pump is reported to be functioning well. She is on a moderate intrathecal dose of 8 mg of Dilaudid per day. Her pain scores are reported to be 7-8/10.

The patient was seen in follow up on 08/31/09. She has moderate swelling on both feet and lower extremities. She reports losing over 4 pounds of fluid weight 2 weeks ago when she received an asthma block. The patient's pump was refilled and her pain scores are reported to be 4-6/10. The cellulitic infection of her legs is reported to be somewhat stable. She has completed her antibiotic coverage and is being followed by her internist.

On 09/23/09 the claimant underwent a right lumbar sympathetic block under fluoroscopy and a left paravertebral nerve root block under fluoroscopy.

On 10/19/09 the patient was seen in follow up. The physician reports that this is one of the worst cases of CRPS he has seen for years. She is reported to have had to go in and out of the hospital instead of being treated in an appropriate manner. She is reported to have had to go to the emergency room with an acute exacerbation of her CRPS and she is reported to have globalized peripheral edema with skin ulceration and breakdown. She went to the hospital and required IV diuretic therapy which has helped her lose over 15 pounds of fluid weight. Her skin is reported to be mottled in appearance. She has clear ulcerative condition and apparently she has developed cellulitis secondary to CRPS and delay of treatment. She received a refill of her intrathecal pump. She is reported to be allergic to Prialt which is reported to be very good in refractory cases. She is continued on Paxil in the morning, Topomax 100 mg TID and Norco for breakthrough pain and Clonazepam at night.

The patient was seen in follow up on 11/05/09. She is reported to be doing well with a combination of oral medication management and intrathecal Morphine therapy. Her diuretic is keeping her fluids down and she is showing signs of cellulitis. She is continued on her oral medication.

The claimant was seen in follow up on 11/17/09. She is reported to have been on chronic intrathecal therapy for well over 1 year. She has chronic pain complaints associated with disseminated CRPS. Her intrathecal pump therapy is reported to manage her pain to at least 50 percent. She subsequently underwent a refill.

The claimant was seen in follow up on 12/09/09. She is reported to be upset with the insurance company and she is reported to have received excellent blockade utilizing lumbar sympathetic approach. She has been seen by multiple physicians who are all reported to agree that her chronic edema is associated with her intractable CRPS. She is reported to have lost from 8-10 pounds with sympathetic blockade. She subsequently underwent pump refill and was recommended to undergo additional sympathetic blocks.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

In the Reviewer's opinion, the request for bilateral lumbar sympathetic blocks under fluoroscopy with IV sedation is not supported by the submitted clinical information. The Reviewer noted that there is a lack of documentation regarding the patient's previous response to sympathetic blocks. The last documented sympathetic injection occurred on 09/23/09. Post procedurally the patient is reported to have had excellent response with a reduction in peripheral edema. The record does not provide any data quantifying the patient's response. There is no indication from the submitted records that the patient has had a decrease in use of oral medications, improved functional response, increased activity levels.

## REFERENCES:

The 2010 Official Disability Guidelines, 15th edition, The Work Loss Data Institute. Online edition.

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)**