

SENT VIA EMAIL OR FAX ON
Dec/07/2009

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/04/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

In-home personal assisted care services from 9/20/2008 thru 3/7/2009

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Legal summary

Records, letters and legal request from pages May/1986 thru 10/13/09
request permission to withdraw as counsel

Letter from regarding Motion for Continuance

Correspondence.

FCE 1 Rehabilitation 2/19/?

Hearing Transcript 6/2/09

Letter and Medical Records from Dr.

Medical Records from Dr.

Medical Records from Dr.

Medical Records Dr.

RME Dr.

IME Dr.

Vocational Assessment RSA/

Affidavit of

Operative Report Dr.

Prialt package insert

HHS letter
Request for Benefit Review
TWCC forms, Correspondence and Benefits Review.

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured in xxxx. He apparently had a fractured ankle and developed RSD that involved 4 extremities and trunk. He apparently had multiple spinal cord stimulators and pain pumps, including one MRSA infection. The FCE date was not recorded. It was apparently performed in the past year based upon his age. The FCE showed him to be in constant pain. The testing showed no grasp. The report stated "He is unable at most times to comfortably stand, walk, climb stairs or reach above shoulder level....Due to his inability to perform the vast majority of functional or lift tasks safely, his body mechanics, coordination and object pace control are reported as very poor. His flexibility, endurance and activity tolerance are all minimally functions." He is unable to walk without assistive devices. Further he wrote "Mr.xxxxx is functional at a subsedentary level only at most times." He was not able to work or drive. There were self-described limitations including his inability to cook, drive, clean, take out trash, walk (limits of 40 feet with a walker), stand, shop, exercise, etc.

There are comments of legal descriptions of a contract signed in 1991 for personal assistance 8 hours a day, 7 days a week. There is a bill for services including food preparation, feeding, bathing holding beverages, dressing, grooming him, transferring, bathing him, reading to wife did many activities for him. (He could not hold the reading material) and writing. He was unable to change position.

There is a page of an affidavit that is neither dated nor signed. It describes his inability to change positions, dress and undress, bend, flex, use buttons on phones, remotes, turn on/off light switches, hold a razor, cup/bottle, etc. His arms shake and his arms and legs have jerks. He appears to spend most of his time in one position on a couch.

There is an itemized EOB from Liberty Mutual describing services for a mammory duct galactogram from 9/08-1/09.

The deposition of 2009 included videos taken in 2007 and 2008 of this man driving, washing a car, walking, having ice cream, smoking, putting coins in a video slot, etc. In the deposition, the man reports he still has RSD and has good and bad days. There were discussions over the extent and progression of his RSD. He defended his function as having good and bad days, a stellate block, etc. He stated his condition worsened by an MRSA infection in 2006. Other witnessed testified about his functional capabilities.]

Dr. wrote a letter dated 6/23/09 stating that after his evaluation of the medical records, the man had significant deficits in his ADLs and warranted a personal care attendant 8 hours a day, 7 days a week.

He was felt to be "unemployable" by of RSA.

Dr. performed and IME on 8/5/08. Dr. reviewed CDs of physical activity by this man. Dr. examination described no abnormalities and felt that this man was capable of working. He had functional use of his hands. The examination reported normal muscle bulk and tone with normal motor function. He walked "independent with use of an assistive device." He was described as being "very inconsistent with presentation and objective findings." He did not need a wheelchair or cane. He felt there was submaximal effort and mimicked muscle spasticity. Dr. answered this in his 10/28/08 note. He also noted the patient and wife noted a cursory exam by Dr.. Dr.'s description is in the next paragraph. He also commented (12/4/08) that the man seen in the videos had different function than that in his office, and he was discharged.

Dr. described lower extremity edema, dystropic nails, allodynia and hypesthesia. Dr. and Dr.

reported a third stage RSD being present. Dr. described excoriations of the legs, with brown edema, pitting edema, atropic skin and nails, foot drop and weakness. He also described hyperesthesia.

Dr. exam was 2/12/08. He noted pain, and spasms on examination. He felt the man had RSD and was not able to work.

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

The first question is whether he has RSD. The Reviewer is not clear if he had the disorder. The findings of RSD are variable. The ODG notes the difficulty in establishing the criteria for a diagnosis. The only consistent findings are would be edema and hyperesthesia and allodynia. There was some comments on nail and skin atrophy, but others did not comment upon them. He is obese and has some CHF. This could explain some of the leg edema. Dr. felt the hyperpathia and allodynia were not present when the man was distracted. Several doctors were committed to the diagnosis of RSD and provided the multiple interventions and pump refills.

The question for the Reviewer is whether or not this man needed personal care services retroactively from 9/20/08 thru 3/7/09. Again, this goes back to the diagnosis and functional problems from the RSD. Again, the first question of the diagnosis and functional loss go back to Dr. examination. The examination itself was only a few lines. The key descriptions in the examination are in Dr. answers to the posed questions, especially after reviewing the provided videos. The Reviewer would have held a single doctor's opinion suspect considering the other physicians input. There is a caveat. Dr. strongly condemned Dr. opinion and decision until he also saw the videos. The Reviewer does not know what the Administrative Judge determined. The Reviewer read in the hearing transcript that this man had good days and bad days. Therefore his functional level fluctuates. That may be true, but the Reviewer wonders what is the probability that the video recordings were on good days, and the doctors over nearly 20 years only saw him on the bad days. Its possible he had need for the services for a time frame prior to the surveillance dates in 2007, but he did not need them for the dates 9/20/2008 thru 3/7/2009.

CRPS, diagnostic criteria

Recommend using a combination of criteria as indicated below. There are no objective gold-standard diagnostic criteria for CRPS I or II. A comparison between three sets of diagnostic criteria for CRPS I concluded that there was a substantial lack of agreement between different diagnostic sets. ([Perez, 2007](#))

A. CRPS-I (RSD):

The IASP (International Association for the Study of Pain) has defined this diagnosis as a variety of painful conditions following injury which appear regionally having a distal predominance of abnormal findings, exceeding in both magnitude and duration the expected clinical course of the inciting event and often resulting in significant impairment of motor function, and showing variable progression over time. ([Stanton-Hicks, 1995](#)) Diagnostic criteria defined by IASP in 1995 were the following: (1) The presence of an initiating noxious event or cause of immobilization that leads to development of the syndrome; (2) Continuing pain, allodynia, or hyperalgesia which is disproportionate to the inciting event and/or spontaneous pain in the absence of external stimuli; (3) Evidence *at some time* of edema, changes in skin blood flow, or abnormal sudomotor activity in the pain region; & (4) The diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain or dysfunction. Criteria 2-4 must be satisfied to make the diagnosis. These criteria were found to be able to pick up a true positive with few false negatives (sensitivity 99% to 100%), but their use resulted in a large number of false positives (specificity range of 36% to 55%). ([Bruehl, 1999](#)) ([Galer, 1998](#)) Up to 37% of patients with painful diabetic neuropathy may meet the clinical criteria for CRPS using the original diagnostic criteria. ([Quisel, 2005](#)) To improve specificity the IASP suggested the following

criteria: (1) Continuing pain disproportionate to the inciting event; (2) A report of one *symptom* from each of the following four categories and one *physical finding* from two of the following four categories: (a) Sensory: hyperesthesia, (b) Vasomotor: temperature asymmetry or skin color changes or asymmetry, (c) Sudomotor/edema: edema or sweating changes or sweating asymmetry, or (d) Motor/trophic: reports of decreased range of motion or motor dysfunction (weakness/tremor or dystonia) or trophic changes: hair, nail, skin. This decreased the number of false positives (specificity 94%) but also decreased the number of true positives (sensitivity of 70%). ([Bruehl, 1999](#))

The Harden Criteria have updated these with the following four criteria: (1) Continuing pain, which is disproportionate to any inciting event; & (2) Must report at least one symptom in three of the four following categories: (a) Sensory: Reports of hyperesthesia and/or allodynia; (b) Vasomotor: Reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry; (c) Sudomotor/Edema: Reports of edema and/or sweating changes and/or sweating asymmetry; (d) Motor/Trophic: Reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); & (3) Must display at least one sign at time of evaluation in two or more of the following categories: (a) Sensory: Evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or temperature sensation and/or deep somatic pressure and/or joint movement); (b) Vasomotor: Evidence of temperature asymmetry (>1°C) and/or skin color changes and/or asymmetry; (c) Sudomotor/Edema: Evidence of edema and/or sweating changes and/or sweating asymmetry; (d) Motor/Trophic: Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); & 4. There is no other diagnosis that better explains the signs and symptoms ([Harden, 2007](#))

The Washington State Department of Labor and Industries guidelines include the presence of four of the following physical findings: (1) Vasomotor changes: temperature/color change; (2) Edema; (3) Trophic changes: skin, hair, and/or nail growth abnormalities; (4) Impaired motor function (tremor, abnormal limb positioning and/or diffuse weakness that can't be explained by neuralgic loss or musculoskeletal dysfunction); (5) Hyperpathia/allodynia; or (6) Sudomotor changes: sweating. Diagnostic tests (only needed if four physical findings were not present): 3-phase bone scan that is abnormal in pattern characteristics for CRPS. ([Washington, 2002](#))

The State of Colorado Division of Workers' Compensation Medical Treatment Guidelines adopted the following diagnostic criteria in 2006: (1) The patient complains of pain (usually diffuse burning or aching); (2) Physical findings of at least vasomotor and/or sudomotor signs, allodynia and/or trophic findings add strength to the diagnosis; (3) At least two diagnostic testing procedures are positive and these procedures include the following: (a) Diagnostic imaging: Plain film radiography/triple phase bone scan, (b) Injections: Diagnostic sympathetic blocks, (c) Thermography: Cold water stress test/warm water stress test, or (d) Autonomic Test Battery. The authors provide the following caveat: Even the most sensitive tests can have false negatives, and the patient can still have CRPS-I, if clinical signs are strongly present. In patients with continued signs and symptoms of CRPS-I, further diagnostic testing may be appropriate. ([Colorado, 2006](#))

Other authors have questioned the usefulness of diagnostic testing over and above history and physical findings. ([Quisel, 2005](#)) ([Yung, 2003](#)) ([Perez2, 2005](#)) A negative diagnostic test should not question a clinically typical presentation of CRPS and should not delay treatment. ([Birklein, 2005](#))

B. CRPS-II (causalgia):

Nerve damage can be detected by EMG but pain is not contained to that distribution. ([Stanton-Hicks, 1995](#)) CRPS I and II appear to be clinically similar. ([Bruehl, 1999](#)) CRPS-II is defined by the IASP as: (1) The presence of continuing pain, allodynia, or

hyperalgesia after a nerve injury, not necessarily limited to the distribution of the injured nerve; (2) Evidence at some time of edema, changes in skin blood flow, and/or abnormal sudomotor activity in the region of pain; & (3) The diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain and dysfunction. The state of Colorado also uses the above criteria but adds that there must be documentation of peripheral nerve injury with pain initially in the distribution of the injured nerve. ([Colorado, 2006](#))

C. Differential Diagnoses of CRPS

These need to include local pathology, peripheral neuropathies, infectious processes, inflammatory and vascular disorders. ([Quisel2, 2005](#)) ([Stanton-Hicks, 2006](#)) Also include the following conditions: pain dysfunction syndrome; cumulative trauma syndrome; repetitive strain syndrome; overuse syndrome; tennis elbow; shoulder-hand syndrome; nonspecific thoracic outlet syndrome; fibromyalgia; posttraumatic vasoconstriction; undetected fracture; post-herpetic neuralgia; diabetic neuropathy. ([Stanton-Hicks, 2004](#)) Others have suggested that likely differential diagnoses should include: (1) Disuse; (2) Somatoform disorder (symptoms related to psychological factors); & (3) Factitious disorder (deliberately feigning symptoms). ([Barth, 2009](#)) See also [Treatment for CRPS](#); [Sympathetically maintained pain](#) (SMP); [CRPS, medications](#); [CRPS, prevention](#); [CRPS, sympathetic and epidural blocks](#).

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

ACOEM-AMERICA 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)