C-IRO Inc.

An Independent Review Organization
7301 RANCH RD 620 N, STE 155-199A
Austin, TX 78726
Phone: (512) 772-4390
Fax: (512) 519-7098
Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Feb/13/2010
IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar Sympathetic Block L2-3 (right)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

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

[ ] Upheld (Agree)
[X] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines Treatment in Workers' Comp 2010 updates, Chapter pain
Operative reports, Dr. 09/05/07, 01/09/09, 04/23/09
MRI right ankle, 06/17/08
Office note, Dr., 08/06/09
Office notes, Dr., 09/22/09, 10/21/09
Peer reviews, 10/19/09, 11/03/09
Case management note, Dr., 10/21/09
Office note, Dr., 12/30/09
Adverse Determination Notices, 11/3/09, 10/19/09

PATIENT CLINICAL HISTORY SUMMARY
This is a male who is status post 09/05/07 revision of external fixator of the right lower extremity, primary closure of medial fasciotomy, placement of wound vac lateral fasciotomy, incision and drainage of superficial abscess. The preoperative diagnoses were right Schatzker 5 tibial plateau fracture, open fasciotomies right leg, complication of external fixator right, and cellulitis to the right thigh. On 01/09/09, the claimant underwent hardware removal of right tibial plateau fracture and on 04/23/09 deep hardware removal. Dr. evaluated the claimant on 09/22/09 and 10/21/09. Dr. noted no allodynia and slight swelling. Dr. evaluated the claimant on 12/30/09. The examination revealed a mottled appearance, some swelling and range of motion limited by pain in the right knee and ankle. The diagnosis was neuropathic pain. The claimant has been treated with Lyrica, Norco, a home exercise program and bracing.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
The treating physician has very clearly documented that he hopes to provide a single lumbar sympathetic block both for diagnostic and potentially therapeutic purposes. When one turns to the ODG Guidelines regarding a lumbar sympathetic block, chronic regional pain syndrome is certainly an indication. The guidelines do not state that chronic regional pain syndrome must be proven beyond all reasonable doubt before the provision of a block. Rather, the guidelines state, “These blocks can be used diagnostically.” Indeed, this is a case where complex regional pain is

suspected and has been unresponsive to medications. The doctor is seeking to clarify the diagnosis and further treatment planning. The ODG Guidelines allows for the diagnostic use of a lumbar sympathetic block in suspected chronic regional pain syndrome. The information provided does satisfy the ODG guidelines. The reviewer finds that medical necessity exists for Lumbar Sympathetic Block L2-3 (right),

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, Chapter pain

Diagnostic criteria for CRP

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.

CRPS sympathetic and epidural treatment. Recommended only as indicated below, for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. 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.

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-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
[X] 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)