

Notice of Independent Review Decision

DATE OF REVIEW: MAY 5, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for left lumbar sympathetic block under fluoroscopy with IV sedation for the left foot and ankle.

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

The physician reviewing this case is American Board Certified in Anesthesiology with a secondary specialty in Pain Management.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Per the Employer's First Report the claimant injured her left ankle when she fell in a pothole at work.

On June 7, 2006, a MRI of the left ankle was taken, read by, M.D. Impression:
1. There is grade I strain from acute injury versus acute plantar fasciitis of the plantar fascia at its inferior calcaneal attachment. 2. Small ankle effusions are appreciated. 3. There is mild tibialis posterior tenosynovitis. 4. The deltoid and lateral ligament components are intact.

On October 31, 2006, the claimant underwent a 3-phase bone scan, read by, M.D. Impression: 1. No abnormal blood flow or soft tissue deposition left foot. 2. The left foot demonstrates a less prominent degree of punctuate uptake 5th metatarsal compared to the right probably relating to degenerative change at the 5th metatarsal heads bilaterally.

On November 14, 2006, , M.D. performed a DDE on the examinee and placed her not at MMI. Recommendations: repeat MRI and 3-phase nucleotide flow study.

On November 20, 2006, , D.O, a pain management physician, evaluated the examinee. Diagnosis: Complex regional pain syndrome stage 1 following a sprain/strain ankle as a result of a work-related injury.

On December 1, 2006, , M.D. performed an EMG on the examinee. Impression: Abnormal EMG study. EMG findings show signs of denervation in the left peroneus longus, left medial gastronemius and left anterior tibialis musculature. Recommend EMG of the lumbar paraspinal musculature to rule out radiculopathy. If these studies are normal then an obvious peripheral neuropathy exists. Clinical correlation is suggested.

On March 22, 2007, per the operative report, M.D. performed a left ankle arthroscopic debridement of meniscoid lesion. There was an arthrofibrotic meniscoid lesion overhanging the lateral shoulder of the talus causing impingement.

On August 24, 2007, Dr. performed a re-examination on the examinee. Findings: The examinee continues to have spasm, intense pain, hyperesthesia, temperature changes, and involuntary movements of her left foot. Treatment: Continue her on Norco 3 times per day and add Clonazepam.

On August 29, 2007, a Benefit Contested Case Hearing was held. Decision: The compensable injury on November 21, 2005 extends to and includes arthrofibrosis with meniscoid lesion of the left ankle and RSD/CRPS. The claimant had disability from 8/9/06 to 5/9/07 as a result of the injury of November 21, 2005.

On December 12, 2007, , M.D., a PM&R physician, performed a peer review on the examinee. Conclusions: Mild case of RSD and left ankle strain.

On October 19, 2009, , D.O. re-examined the examinee. Medications: The examinee is getting good relief and good sleep for the first time with my drug regimen including Lyrica, Klonopin, and Norco 3 times per day.

On November 11, 2009, per the operative report, D.O. performed a left lumbar sympathetic block under fluoroscopy.

On January 6, 2010, per the operative report, D.O. performed a left lumbar sympathetic block under fluoroscopy.

On January 13, 2010, , D.O. re-examined the examinee. Medications: Lorcet, which she has lowered now down to 7.5mg, continue with Lyrica, Prozac, and Clonazepam.

On February 17, 2010, per the operative report , D.O. performed a left lumbar sympathetic block under fluoroscopy.

On February 25, 2010, , D.O. re-examined the examinee. Medications: Ketamine, neuropathic Gabapentin cream was added.

On April 5, 2010, IMO denied the lumbar sympathetic block under fluoroscopy. Reason for denial: The claimant has had 3 blocks and is doing much better. The examinee is 70% improved and she has returned to work full time.

On April 19, 2010, , D.O. responded to the denial from IMO. Response: The appropriate level of care for Ms., which happens to be within the ODG Guidelines, is to continue with sympathetic blockade as long as further blocks offer further improvement. She has noted more than the 50% improvement, which is considered adequate relief for this treatment to be continued. At this point, under section 5, acute exacerbations, which we will consider Ms. Williams now having, may require one to three blocks as it is stated.

PATIENT CLINICAL HISTORY :

On November 21, 2005, the claimant injured her left ankle when she fell in a pothole at work.

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

The adverse decision to deny additional left lumbar sympathetic blocks should be overturned for the following reasons:

1. The claimant has achieved good partial results from the three lumbar sympathetic blocks received. The claimant is 70% improved and has returned to work full time, which demonstrates motivation.
2. Dr. has not only achieved the 70% improvement, he has also achieved reduced quantity of pain and neurotropic medication, which gives distinct medical advantages. Furthermore, additional lumbar sympathetic blocks could decrease both in the quantity and types of medication currently taken.
3. Per the ODG Guidelines, additional lumbar sympathetic blocks are authorized if a consistent pattern of improvement is noted, this is true in this case. The Guidelines state that up to six (6) blocks may be given in those circumstances. In this case, there has been only three (3) blocks with considerable improvement. With the additional blocks, there is a high medical probability in this case that the achievement of being symptom free of the Complex Regional Pain Syndrome could be obtained.

<p>Regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, & lumbar sympathetic block)</p>	<p>Recommendations are generally limited to diagnosis and therapy for CRPS. See CRPS, sympathetic and epidural blocks for specific recommendations for treatment. Also see CRPS, diagnostic criteria; CRPS, medications; & CRPS.</p> <p><i>Stellate ganglion block (SGB) (Cervicothoracic sympathetic block):</i> <i>Lumbar Sympathetic Blocks:</i> There is limited evidence to support this procedure, with most studies reported being case studies. <i>Anatomy:</i> Consists of several ganglia between the L1 and L5 vertebra. <i>Proposed Indications:</i> Circulatory insufficiency of the leg: (Arteriosclerotic disease; Claudication: Rest pain; Ischemic ulcers; Diabetic gangrene; Pain following arterial embolus). Pain: Herpes Zoster; Post-herpetic neuralgia; Frostbite; CRPS; Phantom pain. These blocks can be used diagnostically and therapeutically. <i>Adjunct therapy:</i> sympathetic therapy should be accompanied by aggressive physical therapy to optimize success. <i>Complications:</i> Back pain; Hematuria; Somatic block; Segmental nerve injury; Hypotension (secondary to vasodilation); Bleeding; Paralysis: Renal puncture/trauma. Genitofemoral neuralgia can occur with symptoms of burning dysesthesia in the anteromedial upper thigh. It is advised to not block at L4 to avoid this complication. <i>Adequacy of the block:</i> This should be determined, generally by measure of skin temperature (with an increase noted on the side of the block). Complete sympathetic blockade can be measured with the addition of tests of abolition of sweating and of the sympathogalvanic response. (Day, 2008) (Sayson, 2004) (Nader, 2005)</p>
<p>CRPS, sympathetic and epidural blocks</p>	<p>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)</p>

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)