

Notice of Independent Review Decision

**DATE OF REVIEW: 09/01/2011**

**IRO CASE #:**

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

Bilateral Lumbar Sympathetic Blocks x 3

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

Board certified in Physical Medicine and Rehabilitation with expertise in pain management, wound management and geriatrics.

**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.

Upon independent review, I find that the previous adverse determination and adverse determination on appeal should be overturned. The ODG criteria has been met for the requested service.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records Received: 16 page fax 08/12/11 IRO request, 5 emailed documents page counts 100, 118, 120, 128, 30 received 08/15/11 URA response to disputed services including administrative and medical, 33 page fax 08/15/11 Provider response to disputed services including administrative and medical. Dates of documents range from 4/14/07 to 08/12/11

**PATIENT CLINICAL HISTORY [SUMMARY]:**

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This claimant has a date of birth of xx/xx/xxxx. The notes indicate there was an injury to the shoulder on xx/xx/xxxx. Other records indicate the injury was xx/xxxx. She did complain of shoulder pain which was treated with therapy and then work hardening. She was able to perform at a sedentary level. Dr. notes on 4/10/2008 that the patient is walking with a limp, the pain is spreading to the right leg and light touch feels like sandpaper on the leg. He does suspect CRPS. The diagnosis of CRPS has been debated by the physicians who have seen the patient. Dr. has noted swelling, temperature changes and a mottled skin appearance in the extremities. Dr. 8/3/2011 note indicates there is leg pain with hypersensitivity. He indicates she had a sympathetic blockade with good effect. Her medications in August are Effexor, Neurontin, MSContin, Clonazepam. She continues to have sudomotor and vasomotor changes. There is a request for lumbar sympathetic block times three.

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

This claimant has had pain since 2007. The documented physical examinations do clinically support CRPS. The notes indicate that she has had sympathetic blocks. However there is not documentation of improvement with the blocks – such as medication decrease, improved range of motion, or increased tolerance to activity and decreased allodynia. It is also not evident that physical therapy was incorporated with the blocks to attempt to increase activities. There is also documentation of psychological distress but no evidence of appropriate treatment for this.

Based on the clinical evidence that there are symptoms of CRPS that has spread to all extremities and the lack of documentation of a trial of sympathetic blocks, the blocks requested are appropriate.

As there has been no initial therapeutic phase, I would agree with 3 blocks provided in quick succession over two weeks. There should be a formal test of the block such as change in skin temperature and this should be documented. The claimant should have therapy during this time and there should be documentation of improved activity tolerance. There should be documentation of reduced medication use.

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

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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](#))

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

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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)