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Notice of Independent Review Decision

DATE: January 16, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Evaluation with for Reflex Sympathetic Dystrophy and Pain Management

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

The reviewer is certified by the Texas Board of Chiropractic Examiners with 17 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

08/03/11: Medical Review and Medical
09/05/11: Followup Visit
09/27/11: Initial Examination
09/28/11: New Patient Visit
10/05/11, 10/20/11, 11/17/11, 12/28/11, 01/11/12, 02/15/12, 02/29/12, 03/15/12,
03/26/12, 04/09/12, 04/23/12, 05/07/12, 05/21/12, 06/12/12, 06/26/12, 08/01/12,
08/31/12, 09/14/12, 10/12/12, 11/13/12, 12/17/12: Followup Visits
10/18/11: MRI Right Hand report
10/26/11, 01/11/12, 02/29/12, 04/25/12, 05/29/12, 06/26/12, 08/18/12, 09/11/12,
10/16/12, 11/20/12, 12/18/12: Patient Notes
02/08/12: Consultation
03/21/12: Operative Report
03/21/12: Radiology Report
04/05/12, 05/30/12: Followup Visit
05/17/12: Initial Diagnostic Screening
05/24/12, 07/27/12, 08/24/12, 09/20/12, 11/19/12: Followup Note
05/31/12, 06/14/12, 07/13/12: In Office Procedure Note

06/08/12: Letter
08/14/12: Designated Doctor Examination
09/07/12: MRI Cervical Spine without Contrast report
10/18/12: Pre-Authorization Request
10/23/12: UR performed
10/25/12: Reconsideration Request
11/01/12: UR performed
Article: Pain Banishment Not Pain Management

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who sustained a work-related injury on xx/xx/xx when a heavy box fell on her right hand causing a crush injury.

08/03/11: Medical Review and Medical Assessment: Final of 1% whole person impairment.

09/27/11: The claimant was seen for initial evaluation. It was noted that she had seen, who gave her an injection at the right index finger DIP, which caused extreme pain. It was noted that when she saw, he noted that the injection appeared to be an incorrect procedure. Her medications included Medrol dose pack, Lyrica, and Volteran. On physical exam, she had severe, marked point tenderness to palpation of the right index finger extending into the posterior right 2nd metacarpal area. Any type of movement of the digit produced severe pain. Range of motion of the right index finger showed DIP 34 degrees, marked pain, extension -2 degrees. PIP showed flexion 72 degrees, marked pain, and -2 extension. There was minimal discoloration of the right digit, more in the appearance of hyperemia. There was no evidence of loss of hair follicles of the right hand. IMPRESSION: Right index finger injury with right hand pain. TREATMENT PLAN: Followup in one week, maintain modified work status for one week, MRI right hand, refer to.

10/18/11: MRI Right Hand report interpreted. IMPRESSION: No internal derangement of the right hand.

02/08/12: The claimant was evaluated for right index finger pain. On physical exam, she had marked swelling, shininess, allopathy, and hypodynia of the right index finger. DIAGNOSIS: Chronic pain syndrome, type 2. PLAN: I would like to go ahead and get a cervical sympathetic block on the right side and review her once this has been accomplished.

03/21/12: Operative Report. POSTOPERATIVE DIAGNOSIS: Right chronic regional pain syndrome, type 2. OPERATIVE PROCEDURES: Right sympathetic block, cervical.

03/26/12: The claimant was evaluated. She noted that her pain level post stellate ganglion injection on the right hand side was between 1 and 2 ½. It was noted that she felt dramatic increase in her ability to perform movement with her right hand no longer was hypersensitive, particularly regarding the right index finger.

On physical exam, there was remarkably less point tenderness to the right index finger and right posterior hand as compared to before. Color of the right index finger was much more appropriate compared to prior to the injection. Strength of the right index finger was improved and was 4+/5, though reduced secondary to pain. PLAN: Followup in two weeks, maintain no work status for two weeks, continue medication management, followup.

04/05/12: The claimant was evaluated. It was noted that she had 90% relief of her complaints, but the pain had slowly come back. On physical exam, she still had allodynia and hyperpathia. PLAN: I am going to repeat her cervical sympathetic block on the right side.

04/09/12: The claimant was evaluated. She stated that her pain reduction had lasted 5-7 days post injection but it was now at a level of 7-9/10. She had hypersensitivity of the right index finger and right hand, which extended into the right forearm area. On examination, she had a very cold feeling of the right hand compared to the left hand. There was some notable discoloration primarily in the right index finger and into the right palm area. Strength of the right index finger was reduced again and was 4-/5. Palpation of the right index finger extending into the palm and right forearm showed marked hypersensitivity. PLAN: Followup in two weeks, no work status for two weeks, continue medication management.

04/25/12: The claimant was evaluated. Her current medications included Norco 5/325 mg, ibuprofen 800 mg, and Volteran. It was noted that her medications were helping but caused reflux. She was started on Prilosec OTC. It was noted that she was having difficulty sleeping. She was to continue with current medications and followup for second block.

05/24/12: The claimant was evaluated. She reported pain and dysesthesias in the entire right hand. Her pain was fairly constant throughout the day. She described her pain as being burning and sharp in nature. Her pain was aggravated with hand movements and lifting. Her pain was improved with rest. She reported weakness of the right hand. She described associated symptoms of hyperhidrosis, skin color changes, allodynia, and temperature changes. It was noted that she had been using a right wrist splint, which provided some relief. On examination, her gait was antalgic. There was weakness of the right upper extremity and right hand. There was decreased range of motion of the right hand. There was mild swelling of the right hand. Hyperhidrosis was present. ASSESSMENT: Complex regional pain syndrome of the right upper extremity, type 1. PLAN: A compounded cream of ketamine, gabapentin, and lidocaine may be considered. Neuropathic pain medications such as Lyrica, Neurontin, Cymbalta, and Lidoderm patches may be trialed for her CRPS. I discussed with the patient regarding the performance of a series of right stellate ganglion blocks. She has obtained some temporary relief after a single block. Often times, for effective management, a series of stellate will need to be performed. The patient reports pain movements increase pain. One idea would be performing her right stellate ganglion blocks, which hopefully provide her relief, which would enable her to undergo some type of hand physical therapy. We will followup with the patient at

the time of her right stellate ganglion block. I briefly discussed with the patient spinal cord stimulation for management of complex regional pain syndrome, which may be an option if she fails more conservative measures.

05/29/12: The claimant was evaluated. She was prescribed a compound topical pain cream. recommended more stellate ganglion blocks.

05/31/12: In Office Procedure Note. POSTOPERATIVE DIAGNOSIS: Right upper extremity complex regional pain syndrome. PROCEDURE PERFORMED: Right stellate ganglion block with IV sedation.

06/12/12: The claimant was evaluated. She stated that her pain level went between a 2 at best and 4 ½ at worst. On examination, she had less point tenderness and hypersensitivity noted of the right index finger, right thumb, right hand, and right wrist. Her grip strength was increased compared to prior to the injection #1. She noted that after the second injection, her pain level did decrease approximately 75% but had started to come back a little bit. PLAN: Followup in two weeks, no work status for two weeks, continue medication management through.

06/14/12: In Office Procedure Note. POSTOPERATIVE DIAGNOSIS: Right upper extremity complex regional pain syndrome. PROCEDURE PERFORMED: Right stellate ganglion block with IV sedation.

06/26/12: The claimant was evaluated. She noted that her pain level was between 2 ½ and 5/10. It was noted that her 3rd injection had tremendously helped her complex regional pain syndrome. On examination, she had decreased point tenderness and hypersensitivity of the right finger, right thumb, and right hand into the wrist. Grip strength post #3 injection showed left side 53 pounds and right side 7 pounds. There was no noted hair follicle reduction of the right index finger, though the right index finger did remain very cold to the touch and appeared to have some hypoemia. PLAN: Followup in 30 days, no work status for 30 days, continue medication management per.

07/13/12: In Office Procedure Note. POSTOPERATIVE DIAGNOSIS: Right upper extremity complex regional pain syndrome. PROCEDURE PERFORMED: Right stellate ganglion block with IV sedation.

07/27/12: The claimant was evaluated. It was noted that she had undergone a total of four stellate ganglion blocks. She reported that her most recent ganglion block provided about 75% improvement in her right hand pain. She described having now some pain located in the right trapezius region. She also said that she had occipital headaches. She denied having any physical therapy. She had not had a TENS unit. She continued to apply a compound analgesic cream. On examination, she had minimal swelling of the right hand. There was decreased range of motion of the right wrist and digits. Motor strength was decreased in the right intrinsic hand muscles and wrist flexors. Palpation of the neck and bilateral shoulder region revealed focal areas of exquisite tenderness consistent with

trigger points. PLAN: The patient has undergone several stellate ganglion blocks with improvement in pain. Her pain, however, is at a bothersome level. She has not had any physical therapy. She has not had a TENS unit. I therefore would recommend a TENS unit for pain control. At this point, I recommend holding off on further stellate ganglion blocks until she is able to enroll in physical therapy. If she starts physical therapy and her pain hinders the patient's ability to participate in physical therapy, we may consider repeating her stellate ganglion blocks, which do appear to be effective at least in providing her some temporary improvement in pain. The patient has pain in the bilateral shoulder region, more so on the right. She has had marked limitation of the right hand and upper extremity from her pain. I believe it is likely that her right upper extremity disuse is now causing some myofascial pain in the bilateral shoulder region. I think physical therapy would improve her right shoulder pain. If not, I think it would be reasonable to consider trigger point injections. She was provided a prescription for Zanaflex 2 mg 1-2 tablets t.i.d. p.r.n. and Lidoderm patches.

08/15/12: Designated Doctor Examination. EXTENT OF INJURY: Based on reasonable medical probability, the extent of injury sustained on xx/xx/xx extends to include right index finger contusion, right trigger finger, and right hand RSD. The extent of the injury does not include other conditions such as cervical injury, headaches, or allergies.

09/07/12: MRI Cervical Spine without Contrast report interpreted. IMPRESSION: Multilevel spondylosis, mild. Mild Chiari I malformation. Consider MRI head to further evaluate if clinically indicated and also may elect to evaluate the remainder of the spinal cord (thoracic MRI) as syrinx can be associated with this finding, though is not evident in the cervical and upper thoracic region.

09/11/12: The claimant was evaluated. She was prescribed Butrans patches and Lidoderm patches.

09/20/12: The claimant was evaluated. She noted that the Butrans patch had been helpful in helping her chronic pain. She also stated that her compound analgesic cream provided some benefit. She had begun physical therapy. She stated that she was considering traveling to undergo transcutaneous electrical stimulation therapy. On examination, she was wearing a right wrist splint. There was some mild allodynia present in the right arm region. PLAN: Patient's cervical MRI results were reviewed with her today. There is finding of Chiari malformation. The patient has been reporting headaches for the past few months. The patient was advised to followup with her primary care physician if she wished for further evaluation of headaches in the setting of Chiari malformation. We will increase her Butrans patch from 5 mg to 10 mg for improved pain control of right hand. She was encouraged to continue with physical therapy. Since she had been making slow progress with conventional therapy directed towards complex regional pain syndrome, I do think it is reasonable for her to consider treatment with transcutaneous electrical stimulation.

10/12/12: The claimant was evaluated. She continued to have great difficulties with hypersensitivity and marked pain in the right upper extremity starting at the right index finger. On examination, she continued to hold her right upper extremity in an antalgic posture. Range of motion of the right index finger was reduced secondary to pain. There was hypersensitivity noted to palpation of this area. PLAN: The patient should be referred, who is a specialist in reflex sympathetic dystrophy type of injuries and disease.

10/23/12: UR performed. SUMMARY: The patient is a female whose date of injury is xx/xx/xx. Treatment to date includes cervical sympathetic blocks, individual psychotherapy, and physical therapy. Treatment progress report dated 09/27/12 indicates that the patient reports that her fingers and thumb get cold, but her pointer finger stays warm and gets swollen. A designated doctor performed on 08/14/12 noted that the extent of injury extends to include right index finger contusion, right trigger finger, and right hand RSD. Current medications include Cymbalta, Volteran gel, Lyrica, hydrocodone/acetaminophen, Lidoderm patch, Butrans patch, and ketamine cream. Note dated 10/12/12 indicates that the patient continued to have great difficulties with hypersensitivity and marked pain in the right upper extremity starting at the right index finger. On physical examination, the patient continues to hold her right upper extremity in an antalgic posture. Range of motion of the right index finger is reduced secondary to pain. There is hypersensitivity noted to palpation of this area. Almost any touch, movement, change in temperature causes extreme discomfort for the patient. Based on the clinical information provided, the request for evaluation is not recommended as medically necessary. is a specialist in, and the patient lives in. It is unclear why the patient cannot be referred to a specialist in. Per telephonic consultation, this is his first experience referring for the alternative therapy that is offered. mentioned that he submitted a 15-page document regarding this alternative therapy, which he said is something similar to acupuncture/electrical stimulation. also stated that since standard treatment has failed, he agreed to the patient's request to submit for this treatment offered. However, without guideline support of the treatment to be offered, and the fact that referral for acupuncture/electrical stim treatment can likely be made locally, the request does not appear to be medically necessary at this time.

11/01/12: UR performed. SUMMARY: During peer-to-peer discussion with today (11/01/12), he stated that the patient did have PT in 2011, and that he recently got authorization for another round of PT, but that the patient only attended a couple of sessions and refused to any of the therapy, saying that it hurt too much. Given current clinical data and evidence-based guidelines (ODG), the reconsideration request for evaluation is not medically necessary. The initial request was non-certified on 10/23/12 noting that is a specialist, and the patient lives. It is unclear why the patient cannot be referred to a specialist. said that treatment is something similar to acupuncture/electrical stimulation, and it is unclear why the patient does not wish to undergo that traditional type of treatment. Presented to me for review was the first 3 pages of a book written regarding a machine designed that provides electromagnetic stimulation to the sympathetic nervous system. No included was the research data to back up claims of improvement in

RSD (CRPS). Without guideline support of the treatment to be offered, and the fact that referral for acupuncture/electrical stim treatment can likely be made locally, the request does not appear to be medically necessary at this time. There is insufficient information to support a change in determination and the previous non-certification is upheld.

11/13/12: The claimant was evaluated. She noted her pain level to be between 2 ½ and 7 ½ out of 10. She continued to have general difficulties with her right upper extremity. She had chronic and constant pain, hypersensitivity to touch and temperature change, and increased pain with activities. She did find that her use of a brace was helpful as well as medication management provided. On examination, she continued to have antalgic posture of the right upper extremity. Observation showed that range of motion was moderately restricted with pain throughout movement. There continued to be hypersensitivity throughout the right upper extremity. PLAN: Followup in 30 days, maintain no work status for 30 days, continue with medication management.

11/19/12: The claimant was evaluated. She rated her pain as 6/10. On examination, she was wearing a right wrist splint. PLAN: Continue present medications with increase. No aberrant issues related to the patient's chronic opioid analgesic therapy identified today. The patient continues to report pain relief and improvement in functional status. We decided to continue the medical management of chronic pain. We will increase her Butrans 10 mg patch and 20 mg patch for improved pain control.

12/17/12: The claimant was evaluated. Her examination was unchanged. The plan remained unchanged. She was to continue interferential and TENS unit.

12/18/12: The claimant was evaluated. It was noted that the Lidoderm patches were making her sick. The patches were reduced to 5%. It was noted that the TENS unit was helpful. She was given a refill prescription for Butrans patch. A sonogram of the left lower extremity was ordered to rule out DVT.

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

After reviewing the file, the extent of injury sustained on xx/xx/xx extends to include the right index finger contusion, right trigger finger, and right hand RSD. Over the course of clinical treatment, the claimant has undergone four stellate ganglion blocks, physical therapy, medication, Butrans and Lidoderm patches, and application of an analgesic cream. The claimant has utilized bracing and home use of an interferential and TENS unit. On September 20, 2012. stated that the claimant was to continue physical therapy but that the claimant was considering travelling to be evaluated for acupuncture/transcutaneous electrical stimulation treatment. On October 12, 2012 noted that the claimant should be referred for evaluation. Based on the ODG guidelines for CRPS, acupuncture/transcutaneous electrical stimulation treatment does not appear to be medically necessary. Clinical co-management of the claimant's treatment provided by her doctors should be accessible in San Antonio, Texas. Upon my

independent review, it is my professional opinion that there is insufficient data to support the clinical evaluation. Therefore the request for Evaluation for Reflex Sympathetic Dystrophy and Pain Management is not medically necessary is non certified.

ODG:

<p>CRPS, treatment</p>	<p>Recommended hierarchy of options as indicated below. The goal is to improve function. Multiple pathophysiological mechanisms are responsible including neuropathic (sympathetic and independently-maintained pain), and immunologic (regional inflammation and altered human leukocyte antigens). Both peripheral sensitization and central sensitization have been proposed. (Ribbers, 2003) (Stanton-Hicks, 2006) There are no evidence-based treatment guidelines but several groups have begun to organize treatment algorithms. Recommendations:</p> <p>1. Rehabilitation: (a) <i>Early stages:</i> Build a therapeutic alliance. Analgesia, encouragement and education are key. Physical modalities include desensitization, isometric exercises, resisted range of motion, and stress loading. If not applied appropriately, PT can actually be detrimental. (b) <i>Next steps:</i> Increase flexibility with introduction of gentle active ROM and stretching (to treat accompanying myofascial pain syndrome). Other modalities may include muscle relaxants, trigger point injections and electrical stimulation (based on anecdotal evidence). Edema control may also be required (elevation, retrograde sympathetic blocks, diuretics and adrenoceptor blockers when sympathetically maintained pain-SMP is present). (c) <i>Continued steps:</i> Continue active ROM; stress loading; scrubbing techniques; isotonic strengthening; general aerobic conditioning; and postural normalization. (d) <i>Final steps:</i> Normalization of use; assessment of ergonomics, posture and modifications at home and work. In some cases increased requirements of analgesic medications, psychotherapy, invasive anesthetic techniques and SCS may be required. See CRPS, spinal cord stimulators.</p> <p>2. Psychological treatment: Focused on improved quality of life, development of pain coping skills, cognitive-behavioral therapy, and improving facilitation of other modalities. (a) <i>Early stages:</i> education. (b) <i>Next steps:</i> clinical psychological assessment (after 6 to 8 weeks): identification of stressors; identification of comorbid Axis I psychiatric disorders (depression, anxiety, panic and post-traumatic stress).</p> <p>3. Pain management: (a) <i>Pharmacological:</i> antidepressants (particularly amitriptyline); anticonvulsants (particularly gabapentin); steroids; NSAIDs; opioids; calcitonin; bisphosphonates; $\alpha 1$ adrenoceptor antagonists (terazosin or phenoxybenzamine). The latter class of drugs has been helpful in SMP. Clonidine has been given transdermally and epidurally. (See CRPS, medications.) Bisphosphonates have some literature support in the presence of osteopenia. (Rho, 2002) (b) <i>Minimally invasive:</i> depends on degree of SMP, stage of rehabilitation (passive or active movement), and response to blocks. (See CRPS, sympathetic blocks.) Responders to sympathetic blocks (3 to 6 blocks with concomitant PT) may be all that is required. For non-responders somatic block or epidural infusion may be required to optimize analgesia for PT. (c) <i>More invasive:</i> After failure of progression or partial relief, consider tunneled epidural catheters for prolonged sympathetic or somatic blocks or neurostimulation with SCS in CRPS-I and II. See CRPS, spinal cord stimulators. Also consider peripheral nerve stimulation in CRPS-II and intrathecal drug delivery in patients with dystonia, failed neurostimulation, long-standing disease, multi-limb involvement and requirement of palliative care. (d) <i>Surgical:</i> Sympathectomy is not generally recommended, but has been considered in patients that respond to sympathetic blocks. Pre-procedure the patient should have outcomes assessed with radiofrequency and neurolytic procedures. (See CRPS, sympathectomy.) Motor Cortex Stimulation has been considered.</p> <p>Outcome measures for all treatments of CRPS: Objective measures such as the Beck Depression Inventory, the State Trait Anxiety Inventory, McGill Pain Questionnaire-Short Form, the Pain Disability Index, & the Treatment Outcomes in</p>
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	<p>Pain Survey (the last three may not meet the APA standards for standardized test in clinical use). See Psychological evaluations. See also CRPS, diagnostic criteria; CRPS, medications; CRPS, prevention; CRPS, sympathetic blocks; & Sympathetically maintained pain (SMP). See also Spinal cord stimulators (SCS).</p>
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<p>Office visits</p>	<p>Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a “flag” to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. <i>Note:</i> The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of “virtual visits” compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy.</p>
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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)**