



IMED, INC.

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NOTICE OF INDEPENDENT REVIEW

NAME OF EMPLOYEE:
IRO TRACKING NUMBER: M2-06-1680-01
NAME OF REQUESTOR: Injured Employee
NAME OF CARRIER: American Home Insurance
DATE OF REPORT: 07/26/06
IRO CERTIFICATE NUMBER: 5320

TRANSMITTED VIA FAX:

IMED, Inc. has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO).

In accordance with the requirement for TDI to randomly assign cases to IROs, TDI has assigned your case to IMED, Inc. for an independent review. The peer reviewer selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the peer reviewer reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal.

The independent review was performed by a matched peer with the treating physician. This case was reviewed by a D.O. physician reviewer who is Board Certified in the area of Pain Medicine and is currently listed on the DWC approved doctor list.

I am the Secretary and General Counsel of IMED, Inc., and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and the provider, the injured employee, injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization. I further certify that no conflicts of interest of any nature exist between any of the aforementioned parties and any director, officer, or employee of IMED, Inc.

REVIEWER REPORT

I have reviewed the records forwarded on the above injured worker and have answered the questions submitted.

Information Provided for Review:

1. Detailed medical records summary.
2. 10/30/04 - Employer's First Report of Injury or Illness.
3. 11/28/97 – Emergency Department record, Dr. Sirvevi Dasa, M.D.
4. 11/28/97 – Imaging report, Kimberley Wherry, M.D.
5. 10/12/02 – Louba Laurie, M.D., radiology report.
6. 10/16/02 – Joel Carp, baseline screening mammogram, Parkland Health & Hospital System.
7. 05/07/03, 07/14/03 – Community Hospital of Mesquite, Dr. Sayez Seis.
8. 10/30/04 – Julio Fajardo, D.C., occupational injury report.
9. 11/03/04 – Julio Fajardo, D.C.
10. 11/11/04 – Linden Dillin, M.D.
11. 11/19/04 – Penn Avenue Imaging Center, J. Fierke, M.D.
12. 11/29/04 – Office visit with Linden Dillin, M.D.
13. 12/21/04 – Consultation, Adoubl Itani, D.O.
14. 01/12/05, 01/31/05 – Daily notes, Julio Fajardo, D.C.
15. 02/15/05 – Required Medical Evaluation, Dr. Melissa Tonn, as well as an FCE on that day.
16. 02/25/05, 03/11/05 – Follow-up office visit, Abdoul Itani, D.O.
17. 03/15/05 – Penn Avenue Imaging Center, J. Fierke, M.D.
18. 04/01/05 – Operative report, Abdoul Itani, D.O.
19. 04/08/05 – Abdoul Itani, D.O.
20. 05/13/05 – Operative report, Abdoul Itani, D.O.
21. 05/20/05 – Office note, Abdoul Itani, D.O.
22. 02/07/05 – Office note, Abdoul Itani, D.O.
23. 06/08/05 – Left lower extremity venous ultrasound, Robert C. Wood, M.D.
24. 07/11/05 – Julio Fajardo, D.C.
25. 07/12/05, 08/03/05, 08/09/05 – Abdoul Itani, D.O.
26. 08/17/05 – Progress note, Daniel Santo, D.C.
27. 09/08/05 – Addendum to RME, Dr. Melissa Tonn.
28. 10/07/05 – Operative report, Abdoul Itani, D.O.
29. 10/27/05 – Reexamination, Kevin Strathdee, D.C.
30. Daily notes 10/31/05, 11/02/05, 11/04/05, 11/07/05, Kevin Strathdee, D.C.
31. 11/11/05 – Operative report, Abdoul Itani, D.O..
32. 11/10/05, 11/15/05, 11/18/05, 11/21/05, 11/22/05, 11/28/05, 11/30/05 – Daily notes, Kevin Strathdee, D.C.
33. 12/20/05 – Office visit, Abdoul Itani, D.O.
34. Daily notes 01/15/06, 01/17/06, 02/10/06, Kevin Strathdee, D.C.
35. 02/16/06 – Abdoul Itani, D.O., follow-up note.
36. 04/13/06 – Operative report, Abdoul Itani, D.O.
37. 04/27/06 – Follow-up note, Abdoul Itani, D.O.

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Clinical History Summarized:

The employee was injured on ___ when she pulled open a freezer door and struck her foot.

11/28/97 – There was an emergency department record by Dr. Sridevi Dasa, M.D. The injured employee was given Demerol and Phenergan for pain control. An x-ray of the left tibia and fibula showed no evidence of acute bony abnormality. The injured employee was given a work release through the following Monday.

11/28/97 – Sridevi Dasa, M.D. The impression on that date was negative examination of the left lower extremity.

10/12/02 – Lakepointe Medical Center Radiology Department – Admitting physician was Louba Laurie, M.D. The impression on that date was markedly enlarged fibroid uterus and 2.2 cm left ovarian cyst most likely physiologic.

10/16/02 – Lakepoint Medical Center Radiology Department – The impression on that date was Category I no mammographic evidence of malignancy. A follow-up mammogram was recommended in one year.

05/07/03 – Parkland Health & Hospital System – Dr. Gerald Dietz, M.D., interpreted an MRI of the left shoulder. The finding was a questionable fracture of the greater tuberosity of the proximal humerus not displaced in a person with history given of a prior location. The shoulder was articulating in a normal fashion on this examination.

07/14/03 – The injured employee was admitted to the Community Hospital of Mesquite for food impaction.

10/30/04 – Left foot three views. No fracture, dislocation, or other bony abnormality was identified. The plantar posterior calcaneal spurring was present. The soft tissues appeared unremarkable.

11/11/04 – A daily note from Texas Injury Clinic by Julio Fajardo, D.C. The physical examination remained unchanged. Dr. Fajardo stated that the injured employee should remain off work, and she may require a bone scan or a thin cut CT depending on the bone specialist's recommendations.

11/11/04 – The injured employee presented to Linden Dillin, M.D. X-rays did not document clear-cut relevant osseous abnormalities. Dr. Dillin noted that the injured employee may have a fracture of her second metatarsal base and possibly the third.

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11/19/04 – Penn Avenue Imaging Center – There was a tri-phasic bone scan of the feet. The conclusion was increased activity on all three phases involving the right lower leg, ankle, and foot suggesting reflex sympathetic dystrophy and correlate clinically. There were a few areas of slightly increased activity involving the left foot on delayed imaging nonspecific but could be due to arthritis.

12/21/04 – Abdoul Itani, D.O. – The injured employee's medications on that date were Maalox and Vicodin. The assessment was reflex sympathetic dystrophy in the left foot. The plan was Neurontin 300 mg for three to five days. Also, a lumbar sympathetic block was recommended.

11/12/05 – Daily note from Julio Farjardo, D.C.

01/31/05 – Daily note from Julio Farjardo, D.C. It was noted the injured employee was returned to work on light duty capacity with very strict restrictions.

02/15/05 – A Required Medical Evaluation (RME) was performed by Dr. Melissa Tonn. The impression was that the injured employee should be discontinued from the use of the fracture walking boot and be instructed immediately to discontinue the use of any compressive durable medical equipment and to switch to an open flexible walking type shoe or sandal. The injured employee's symptomatology should be resolving with increased use of the extremity and a discontinuation of the iatrogenically induced peripheral extremity compression. It was noted the injured employee should elevate the foot and leg on occasion to assist with reduction in the peripheral edema. The injured employee should also be controlled on over-the-counter analgesics, and there was no objective evidence of reflex sympathetic dystrophy.

02/25/05 – Follow-up office note with Abdoul Itani, D.O. It was noted that the injured employee did have severe swelling in the left foot, as well as discoloration and positive hypersensitivity to touch. Follow-up with x-ray was recommended, as well as Neurontin.

03/11/05 – Abdoul Itani, D.O., disagreed with Dr. Tonn's diagnosis that the employee did not have reflex sympathetic dystrophy.

03/15/05 – An imaging review of the right foot x-ray. The conclusion was calcaneal spurring, as well as is likely some calcification or ossification in the distal Achilles tendon that was in the right foot. In the left foot, the conclusions were the bones were markedly demineralized, calcaneal spurring, no significant joint space narrowing.

04/03/05 – Operative Report. The procedure was left lumbar sympathetic block under fluoroscopy.

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04/08/05 – Follow-up visit with Abdoul Itani, D.O. It was noted that the injured employee had improvement with the lumbar sympathetic block, and it was suggested that the lumbar sympathetic block be repeated two additional times.

05/13/05 – Operative report by Abdoul Itani, D.O., consisting of a left lumbar sympathetic block under fluoroscopy.

05/26/05 – Daily noted from Julio Fajardo, D.C., indicated that the injured employee did have reflex sympathetic dystrophy, and upon evaluation, discoloration throughout the digits of the foot with hypersensitivity, especially over the distal metatarsals and MP joints were noted which also indicated that she had very limited mobility of her toes.

05/28/05 – Follow-up note with Abdoul Itani, D.O. It was indicated that the injured employee's pain score was 10/10, and she was off Ultracet and Neurontin. Hydrocodone was also indicated.

06/07/05 – Injured employee returned to Dr. Itani. It was indicated that she still had left foot swelling essentially over the lateral aspect of the ankle. However, her range of motion was improved.

06/08/05 – There was a left lower extremity venous ultrasound. The impression was no left lower extremity deep vein thrombosis.

07/11/05 – A daily note by Julio Farjardo, D.C.

07/12/05 – Abdoul Itani, D.O. It was indicated that the injured employee had a history of reflex sympathetic dystrophy and that the RS stimulator was helping her tremendously. The pain score 0-1/10, and the injured employee was performing physical therapy at home.

08/09/05 – Abdoul Itani, D.O. The injured employee returned for follow-up with complaints of difficulty in sleeping. The RS stimulator was still helping her pain. Her pain score was 3/10.

08/17/05 – Daniel Santo, D.C. The injured employee had presented with a significant amount of swelling the left leg, ankle, and foot, as well as complaints that the pain was migrating over to the right leg.

09/06/05 – Abdoul Itani, D.O. Dr. Itani suggested a lumbar sympathetic block (provided relief the previous times).

09/08/05 – An addendum to the RME of 02/15/05. The conclusion was based on the criteria outlined in the *AMA Guides*, the directives from *AADEPCRPS Physician Paper*, and the

Washington State CRPS Guidelines. The injured employee did not meet the objective diagnostic criteria for the application of the diagnosis of reflex sympathetic dystrophy.

10/07/05 – Operative report. A left lumbar sympathetic block under fluoroscopy by Dr. Itani was performed.

10/27/05 – Reexamination by Kevin Strathdee, D.C. The impression was left ankle, foot, and toes reflex sympathetic dystrophy, status post lumbar sympathetic block number three, and left foot and toe pain with swelling and weakness.

11/02/05 – Kevin Strathdee, D.C., recommended one unit of myofascial therapy to the left foot to reduce pain and swelling.

11/04/05 – Kevin Strathdee, D.C., recommended one unit of myofascial therapy to the left foot to reduce pain and swelling.

11/07/05 - Kevin Strathdee, D.C., indicated the injured employee's foot demonstrated definite slight increased swelling. He recommended post-injection rehabilitation.

11/10/05 & 11/11/05 – Lumbar sympathetic block under fluoroscopy with epidurogram on the side by Abdoul Itani, D.O.

11/10/05 – Daily note from Kevin Strathdee, D.C.

11/18/05 – Daily note from Kevin Strathdee, D.C. He indicated that they would continue with the recommended program consisting of one unit of myofascial therapy three times a week.

11/21/05, 11/23/05, 11/22/05, 11/28/05, 11/30/05 – Daily notes from Kevin Strathdee, D.C.

12/20/05 – Abdoul Itani, D.O. The diagnosis was reflex sympathetic dystrophy. Dr. Itani indicated the injured employee's pain was still 7/10, and that she was on Neurontin and Ultracet on an as-needed basis.

01/05/06 – Daily note from Kevin Strathdee, D.C.

01/17/06 – Abdoul Itani, D.O. Dr. Itani indicated that the injured employee was to continue with exercise, Neurontin, and Ultracet.

02/10/06 – Kevin Strathdee, D.C. The recommendation was to follow-up with Dr. Itani for consideration of an additional lumbar sympathetic block, and the injured employee was taken off work.

02/16/06 – Abdoul Itani, D.O. He indicated the injured employee's left foot was swollen with slight discoloration, and that she was to continue on Neurontin and Ultracet.

02/20/06 – Kevin Strathdee, D.C. The recommendation was an reflex sympathetic dystrophy second opinion, follow-up with Dr. Itani, and she was ordered to return to RS stimulator as it was useful.

03/23/06 – Abdoul Itani, D.O. The physical examination was the left foot was swollen and discolored. It was recommended that she receive LSB on the left side. Her Ultracet and Neurontin was refilled.

04/13/06 – Left lumbar sympathetic block under fluoroscopy by Abdoul Itani, D.O.

04/27/06 – Physical examination by Abdoul Itani, D.O. She had swelling, discoloration, and allodynia over the superior aspect of the foot. The pain score was 8/10, and she continued on Ultracet and Neurontin.

Disputed Services:

Preauthorization denied lumbar sympathetic block, fluro and epidurogram on left side.

Decision:

Preauthorization denial upheld.

Rationale/Basis for Decision:

The employee does not meet the established and accepted diagnostic criteria for CRPS-1. The historical data does not indicate the employee sustained any prolonged or consistent relief with these injections. Thus, efficacy of this treatment modality cannot be established for this injured employee.

The Official Disability Guidelines recommends stellate block “when used for symptom relief and to demonstrate sympathetically maintained pain. (Stanton-Hicks, 2004) A systematic review revealed a paucity of published evidence supporting the use of local anesthetic sympathetic blocks for the treatment of CRPS. (Cepeda, 2005) Regional sympathetic blocks are

use for (1) upper extremity: stellate ganglion block or laparoscopic blocks; or (2) lower extremity; lumbar sympathetic block. Signs of a successful block” temperature rise to 35 degrees, sympathetic skin response using modified ECG; cold pressor test; Laser Doppler flowmetry. This type of evaluation is important, especially if the block is unsuccessful in eliminating pain in order to determine if a complete block was performed. A sensory examination should also be completed in persons with pain relief. Local anesthetic can also result in somatic block that can affect pain. Pain relief may also be due to systemic uptake of local anesthetic or a placebo effect. (Grabow, 2005) Evaluating and treating results should include: (1) complete elimination of pain: consider prolonged neurolytic block; consider the use of a α_1 adrenoceptor blocker such as terazosin; and (2) current suggested guidelines suggest that a maximum sustained benefit is obtained after three to six blocks when used in addition to physical therapy. (Washington, 2002) (Stanton-Hicks, 2006) They also state that even if the original site is unresponsive, future exacerbations of CRPS at the same site or distant site may respond to one to three blocks. (Washington, 2002) Alternatives to regional sympathetic blocks may be necessary when there is evidence of coagulopathy, systemic infection, and/or postsurgical changes. These include peripheral nerve and plexus blocks and epidural administration of local anesthetics. Mixed conduction blocks (central neural blocks) are suggested when analgesic is insufficient by pharmacologic means to support physical therapy: (1) implanted catheters at the brachial or lumbosacral plexus: allows for one to two weeks of therapy. Side effects include technical failure and infection: and (2) epidural tunneled catheters: allows for long-term therapy: side effects: same as above. Clonidine has also been effective intrathecally to reduce dystonia. (van Hilten, 2000) IV regional sympathetic blocks are controversial due to varying success. Guanethadine was used, but is no longer available in the United States. 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 a 30% improvement in pain compared to placebo. 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, 25 sessions) with Guanethidine and Lidocaine resulted in excellent pain relief and full restoration of both function and range of movement of the affected extremity in persons suffering from CRPS-1 of the hand. (Paraskevas, 2005) Local or systemic parecoxib combined with Lidocaine/Clonidine IV regional analgesia is an effective treatment for CRPS-1 in a dominant upper limb. (Frade, 2005).

References:

1. *The American College of Occupational and Environment Medicine Guidelines*. Accessed: 07/26/06.

2. Laxmaiah Manchikanti, M.D., Vijay Singh, M.S., David Kleth, M.D., Curtis W. Slipman, M.D., Joseph F Jasper, M.D., Andrea M. Trescot, M.D., Kenneth G. Varley, M.D., Sairam L. Atluri, M.D., Carlos Giron, M.D., Mary Jo Curran, M.D., Jose Rivera, M.D., A. Ghafoor Baha, M.D., Cyrus E. Bakhit, M.D., and Merrill W. Reuter, M.D. *American Society of Interventional Pain Physician Practice Guidelines. Pain Physician, Volume 4, Number 1, pp 24-98, 2001.*
3. Delisa J. Gans B. Nicholas Walsh N, et al. *Physical Medicine and Rehabilitation: Principles and Practice*, Lippincott Williams & Wilkins; 4th edition (October 30, 2004).
4. *The Official Disability Guidelines, 11th Edition, The Work Loss Data Institute.* (Accessed: 07/26/06).

The rationale for the opinion stated in this report is based on the above references, the record review, as well as the broadly accepted literature to include numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician with IMED, Inc. is deemed to be a DWC decision and order.

YOUR RIGHT TO REQUEST A HEARING

If you are disputing the decision, the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than thirty (30) days after the date on which the decision that is the subject of the appeal is final and appealable.

I hereby verify that a copy of this Independent Review Organization's decision was sent to the respondent, the requestor, DWC, and the injured worker via facsimile or U.S. Postal Service this 28th day of July, 2006 from the office of IMED, Inc.

Sincerely,



Charles Brawner
Secretary/General Counsel