

Clear Resolutions Inc.

An Independent Review Organization

IRO REVIEWER REPORT TEMPLATE -WC

DATE OF REVIEW:

FEBRUARY 26, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Four to six trigger point injections followed one week later with stellate ganglion block.

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

Board-certified Internal Medicine

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

Medical records from Drs.:

Consultation and evaluation dated 1/20/06, 1/30/06, 2/17/06, 2/23/06, 3/6/06, 4/12/06, 4/17/06, 8/7/06, 8/29/06, 9/25/06, 10/3/06, 10/10/06, 12/11/06

Diagnostic imaging studies 2/1/06, 2/15/06

Electrodiagnostic testing 5/8/06

Physical therapy notes 2/1/06 to 1/20/07

Carrier correspondence

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient injured her right hand and forearm in, while scanning merchandise. MRI was normal. Electrodiagnostic testing was normal. She has been treated with prolonged therapeutic modalities. The most recent physical examination shows some reproducible trigger points in the forearm. None of the records demonstrate criteria to diagnose RSD/CRPS.

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

The Patient has myofascial pain in the right forearm, with poor response to the treatment provided. Physical examination shows trigger points. None of the studies or examinations shows evidence for CRPS.

Two or three trigger point injections would be reasonable, as there is objective evidence for muscle spasm. There is no evidence to support the need for a stellate ganglion block. This procedure has no place in the management of myofascial pain or tendonitis.

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)**