

October 19, 2007

REVIEWER'S REPORT

DATE OF REVIEW: 10/17/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Continuous interscalene nerve block.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified in Anesthesiology, practicing Anesthesiology and Pain Management

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

Continuous interscalene nerve blockade is not supported in the literature for management of chronic shoulder pain and disability. It is indicated for acute pain management in conjunction with shoulder procedures including manipulation of the shoulder.

INFORMATION PROVIDED FOR REVIEW:

1. TDI Case Assignment
2. Letters of denial and criteria utilized in denial and URA referral
3. MRI scan of left shoulder dated 05/31/07
4. Treating doctor's office notes dated 05/09/07 through 09/27/07, total of nine visits
5. Physical therapy notes dated 08/08/07 through 09/05/07
6. Therapy and treatment orders and prescriptions dated 10/09/07

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a male who suffered a shoulder injury. An MRI scan revealed a large rotator cuff repair. The patient had a surgical repair of the torn rotator cuff on 06/20/07. Three months postoperatively, the patient continued to have reduced range of motion and pain despite physical therapy. The diagnosis of adhesive capsulitis of the shoulder was made. A manipulation of that shoulder was performed on 10/10/07. The results of that manipulation are not known in this review.

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

The request for continuous interscalene nerve blockade in the setting of chronic shoulder pain and ongoing physical therapy is simply not supported in the anesthetic or pain management literature. The literature provides no guide at all in this setting.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines: Hadzic: Textbook of Regional Anesthesia, McGraw-Hill 2007, pages 403-419.