



Notice of Independent Review Decision

DATE OF REVIEW: 1/15/08

NAME:

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical appropriateness for the previously denied request for tri-phase bone scan and electromyogram/nerve conduction velocity (EMG/NCV) studies of the upper extremities.

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

Texas Licensed Anesthesiologist.

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.

The previously denied request for a tri-phase bone scan is overturned and the EMG/NCV of the upper extremities is upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Request for a Review by an Independent Review Organization dated 1/2/08.

- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 1/7/08.
- Review of Health Care Services dated 12/26/07, 12/10/07.
- Fax Cover Sheet Comments dated 1/8/08.
- Position Statement Letter dated 1/8/08.
- Notice to, Inc. of Case Assignment dated 1/8/08.
- UR Physician Advisor Report dated 12/10/07.
- Medical Necessity dated 12/26/07.
- Required Medical Exam dated 11/14/07.
- Pre-Authorization Request IRO dated 1/2/08.
- Progress Report Letter dated 12/19/07.
- Cervical Spine MRI dated 6/1/07.

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY [SUMMARY]:

Age: xx years

Gender: Female

Date of Injury: xx/xx/xx

Mechanism of Injury: Walked into an ice machine.

Diagnosis:

1. Regional Sympathetic Dystrophy (RSD) (CRPS – Chronic regional pain syndrome, type I).
2. Chronic shoulder pain.
3. Status post right stellate ganglion block.
4. Status post right T2-T3 sympathetic block.

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

The patient is a xx-year-old female who sustained a work related injury on xx/xx/xx, secondary to sustaining trauma to her right arm/shoulder.

Subsequent to the injury, the claimant underwent conservative treatment and diagnostic testing. Initial plain film X-rays of the arm and shoulder were reported as negative. In addition, a cervical MRI showed disk bulging and a shoulder MRI was reported as negative. The claimant was diagnosed clinically with reflex sympathetic dystrophy initially. Secondary to this diagnosis, the requesting provider performed stellate ganglion blocks and a right T2-T3 sympathetic block with reported no pain relief.

A required medical evaluation performed by, M.D., on November 14, 2007, diagnosed the claimant with a right shoulder sprain, with a tiny partial rotator cuff tear and subsequent development of reflex sympathetic dystrophy of the right upper extremity. His opinion was that the patient did not have a complete rotator cuff tear, and there was no indication for shoulder surgery. Recommendation pertaining to claimant's RSD is to consider possible spinal cord stimulator trial. However, in the requesting provider's "To

Whom it May Concern” correspondence submitted, December 19, 2007, he stated that in light of the fact that the claimant has not responded to treatments that are the standard of care for RSD, the claimant needs to undergo diagnostic testing to determine the etiology of the patient’s pain and confirm the diagnosis of RSD. After review of the information submitted, the previous denial for EMG/NCV studies of the upper extremities has been upheld. This diagnostic test will provide minimal to no additional clinical information, as the claimant does not have any objective findings of cervical radiculopathy. In addition, the radiographic imaging studies report of cervical MRI did not reveal any significant disk herniation, nerve root compression, and/or spinal cord compression. The request for the triple phase bone scan has been approved. The successful treatment and diagnosis of RSD rest with early diagnosis while the patient has sympathetically maintained pain. This is a clinical diagnosis that is supported by clinical response to a sympathetic blockade, triple phase bone scan, detailed bone X-ray, and infrared thermography. It is the opinion of this reviewer that the requested testing will help provide the requesting physician to help discern if this claimant’s right upper extremity pain is truly sympathetic mediated.

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 – ELECTRODIAGNOSTIC TESTING.
- 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)

_____ A Practical Approach to Pain Management, edited by Matthew Lefkowitz and Allen Lebovits, Ph.D., Chapter 24 on Reflex Sympathetic Dystrophy.