

NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Workers' Compensation Health Care Non-network (WC)

Original Decision Date: 06/30/2008

Amend Decision Date: 06/30/2008

DATE OF REVIEW: 06/30/2008

AMENDED DECISION DATE: 06/30/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left L-3 lumbar sympathetic block under fluoroscopic guidance

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management physician

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

1. Texas Dept of Insurance Assignment to Medwork 06/10/2008
2. Texas Dept of Insurance notice to URA of assignment of IRO 06/10/2008
3. Confirmation of Receipt of a Request for a Review by an IRO 06/10/2008
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 06/05/2008
6. adverse determination letter reconsideration 05/12/2008
7. adverse determination letter initial review 04/18/2008
8. office note 06/02/2008
9. fax to PA dept 05/05/2008
10. office note 04/28/2008
11. fax to PA dept 04/15/2008
12. office note 04/07/2008, 03/03/2008, 01/30/2008, 12/19/2007
13. Operative report 03/23/2007
14. Open MRI of West Texas 01/30/2007
15. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This is a xx-year-old female who sustained a work-related injury on xx/xx/xx involving her left knee. Subsequent to the injury the claimant underwent a left knee cruciate ligament repair which was performed on March 23, 2007. Subsequent to the surgery, claimant developed severe allodynia and hyperesthesia with sudomotor changes, hypertrichosis and diminished range of motion of the left lower extremity. Patient's BAS score from the follow-up note dated 12/19/07 appears to be 10/10 at its worst with an average of 6/10. Conservative treatment attempted to include medication management of Lyrica 150 mg one p.o. t.i.d., propoxyphene and ibuprofen.

The requesting provider, , M.D. diagnosed claimant with left lower extremity complex regional pain syndrome type I. Triple base bone scan performed (date not specified) revealed the presence of decreased calcification to the lower extremity area. Reportedly, claimant underwent a left L-3 lumbar sympathetic nerve block (date not specified) with more than 80% improved symptomology to include less medication usage. In addition reportedly, claimant's range of motion has greatly improved.

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

After review of the information submitted, it is the opinion of this reviewer that the previous nonauthorization for the requested intervention be overturned. The above requested intervention is commonly used for differential diagnosis and is the preferred treatment of CRPS type I pain involving the lower extremities. For diagnostic testing, one injection should be sufficient. For a positive response, pain relief should be 50% or greater for the duration of the local anesthetic and pain relief should be associated with functional improvement. This claimant has met the criteria to proceed with an additional injection (left L-3 sympathetic nerve block) to be given therapeutically as an adjunct to functional exercise. Of note, the merit of the first injection was measured appropriately and therefore, the approval for the second injection.

Guidelines and References used: Official Disability Guidelines, Treatment Index, Fifth Edition 2008 (web) under pain section - CRPS Treatment.

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)**