

Applied Assessments LLC

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: March 31, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder sympathetic nerve block

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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)

Upon independent review the reviewer finds that the requested right shoulder sympathetic nerve block is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters 3/5/08 and Undated
ODG Guidelines and Treatment Guidelines
MD Exam Notes 1/10/08, 2/5/08, 2/19/08
Peer Review 7/9/07
Pre-Authorization Requests

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a lady who injured her shoulder. She subsequently underwent an arthroscopic repair of the rotator cuff in November 2007. Her recovery has been slow. Dr. wrote that she had reduced shoulder motion and stiffness and diffuse tenderness. He considers mild complex regional pain disorder (RSD) in the differential and wants a sympathetic block for her treatment. He described the shoulder (2/5/08) as “No warmth or erythema to the skin.” .

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

The diagnosis of RSD or CRPS has not been established. Without this establishment, sympathetic nerve block is not recommended as per ODG Guidelines. There are several books describing the disorder. For consistency, I am using The Medical Disability Advisor by Reed. The text describes the disorder as one where “There is no single term or universally accepted case definition for persons with these (my comment-RSD, CRPS) disorders. There is “pain that is present without stimulation or movement, associated with specific objective findings including swelling, skin color changes, sweating changes, temperature changes, reduced passive range of motion and alteration of skin texture.” The book further describes the examination of showing “swelling, local skin color changes or red, or purple, local sweating changes, local temperature changes, reduced passive range of motion and local alteration of skin texture of smooth or shiny in the affected extremity.” I would add complaints of dyesthesias and burning. The examination would show hypersensitivity to temperature with allodynia or hyperpathia. This lady has loss of motion, but this can be attributed to adhesive capsulitis or frozen shoulder. Dr. description of the surgical site and shoulder did not show any of the cutaneous findings mentioned in Reed’s book., nor the sensory findings I mentioned.

The ODG described Complex Regional Pain Disorder as:

Description: Chronic pain occurring after a major injury to the nerves in an upper limb, most commonly seen when a nerve has been completely or partially severed. Pain is constant, burning, and easily aggravated, and there could be tingling or numbness.

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)