Advanced Medical Reviews

ACCREDITED EXTERNAL REVIEW

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 11/6/2009
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1. Is the condition life-threatening?
2. Is the review ordered by a Court?

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from University of Missouri-Kansas City and completed training in Physical Med & Rehab at Baylor University Medical Center. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 7/1/2006 and Pain Management since 9/9/2006. This reviewer currently resides in TX.

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)

1. Is the condition life-threatening? Upheld
2. Is the review ordered by a Court? Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Fax cover sheet by dated 10/19/2009
2. Fax cover sheet by dated 10/19/2009
3. Notice of assignment of independent review organization by dated 10/19/2009
4. Facsimile cover sheet by dated 10/19/2009
5. Facsimile cover sheet by dated 10/16/2009
6. Conformation of receipt of a request for a review by an independent review organization (IRO) by dated 10/16/2009
7. Request for a review by an independent review organization form by dated 10/15/2009
8. Fax cover sheet by dated 10/15/2009
9. Notice of utilization review findings by author unknown dated 10/8/2009
10. Letter by author unknown dated 10/8/2009
11. Fax cover sheet by dated 10/8/2009
12. Fax cover sheet by dated 10/5/2009
13. Progress notes by MD dated 10/2/2009
14. Operative notes by MD dated 3/19/2009
15. Operative notes by MD dated 1/21/2009

16. MRI report of the Right Shoulder W/WO contrast by MD dated 4/5/2007
17. Clinical notes by MD dated 3/1/2007

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The patient is a female with complaints of right shoulder pain, anxiety and depression. Throbbing, aching, cramping pain radiates to the right side of neck. Pain rates as an 8/10. Medication helps very little. Pain affects activities of daily living. General physical examination is non-specific. Cervical spine examination revealed painful, restricted range of motion with tenderness to palpation in the right neck and shoulder muscles. Shoulder examination reveals limited range of motion and positive trophic changes and allodynia of the right upper extremity. Assessment is shoulder pain, adhesive capsulitis, rotator cuff syndrome, myofascial pain syndrome, chronic pain syndrome, depression with anxiety with adjustment disorders, status post spinal cord stimulator implant. Therapy recommendation is physical therapy twice weekly for 5 weeks, psychological evaluation for chronic pain program and continuation of Celebrex, Lyrica; start duragesic, Xanax and Elavil; Stop Cymbalta. Right stellate ganglion block times 3. Notes from 3/2007 also mention similar symptoms concerning for complex regional pain syndrome.

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

The record dated 10/15/2009 states the condition is not considered life-threatening and the review is not ordered by the court. According to the same letter dated 10/15/2009, the requested service in question appears to be a right stellate ganglion block times 3. The request was previously denied on 10/8/2009 and 10/15/2009.

According to the provided medical records a request for stellate ganglion block times 3 does not appear medically necessary. The available case notes indicate the patient has had 2 series of stellate ganglion blocks in 2007 and 2008, in addition to suprascapular nerve blocks and spinal cord stimulator placement. It is unclear what response the patient has had to prior stellate ganglion block. It is unclear what amount of relief has been gained from the spinal cord stimulator and other medications tried. ODG recommends the following criteria for consideration of stellage ganglion block: (1)In the initial diagnostic phase if less than 50% improvement is noted for the duration of the local anesthetic, no further blocks are recommended. (2) In the initial therapeutic phase, maximum sustained relief is generally obtained after 3 to 6 blocks. These blocks are generally given in fairly quick succession in the first two weeks of treatment with tapering to once a week. Continuing treatment longer than 2 to 3 weeks is unusual. (3) In the therapeutic phase repeat blocks should only be undertaken if there is evidence of increased range of motion, pain and medication use reduction and increased tolerance of activity and touch (decreased allodynia) in physical therapy/occupational therapy. (4) There should be evidence that physical or occupational therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase. (5) In acute exacerbations, 1 to 3 blocks may be required for treatment. (5) A formal test of the block should be documented (preferably using skin temperature). (6) Documentation of motor and/or sensory block should occur. This is particularly important in the diagnostic phase to avoid overestimation of the sympathetic component of pain.

Given the lack of information regarding the previous treatment to the right arm consisting of stellate ganglion block the request does not meet ODG recommended medical necessity criteria and recommendation is that the 2 prior decisions to deny be upheld.

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)

ODG. Pain chapter.
CRPS, sympathetic and epidural blocks
-Recommendations (based on consensus guidelines) for use of sympathetic blocks.

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