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Notice of Independent Review Decision

DATE OF REVIEW: 12/07/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Appeal Rt stellate ganglion nerve block w/Fluoroscopy (64510, 77003, 99144)

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

Texas Board Certified Physical Medicine & Rehabilitation
Texas Board Certified Pain Management

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 04/16/09 - Clinical Note - M.D.
2. 04/16/09 - MRI Right Shoulder
3. 05/20/09 - Operative Report
4. 05/22/09 - Clinical Note - M.D.
5. 06/22/09 - Clinical Note - M.D.
6. 07/09/09 - Clinical Note - M.D.
7. 07/16/09 - Right Shoulder Arthrogram
8. 07/16/09 - MR Arthrogram Right Shoulder
9. 10/05/09 - History and Physical
10. 10/06/09 - Operative Report
11. 11/05/09 - Electrodiagnostic Studies
12. 12/10/09 - Clinical Note - M.D.
13. 12/17/09 - Clinical Note - M.D.

14.01/07/10 - Clinical Note - M.D.
15.01/13/10 - Three Phase Bone Scan Right Shoulder
16.01/25/10 - Clinical Note - M.D.
17.02/25/10 - Clinical Note - M.D.
18.04/06/10 - Clinical Note - M.D.
19.05/04/10 - Clinical Note - M.D.
20.05/10/10 - Clinical Note - M.D.
21.05/19/10 - Clinical Note - M.D.
22.06/22/10 - Clinical Note - M.D.
23.06/24/10 - Operative Report
24.07/08/10 - Clinical Note - M.D.
25.07/15/10 - Physical Therapy Note
26.07/16/10 - Physical Therapy Note
27.07/19/10 - Physical Therapy Note
28.07/23/10 - Physical Therapy Note
29.07/26/10 - Physical Therapy Note
30.07/28/10 - Physical Therapy Note
31.08/02/10 - Physical Therapy Note
32.08/04/10 - Clinical Note - M.D.
33.08/11/10 - Clinical Note - M.D.
34.09/15/10 - Clinical Note - M.D.
35.09/20/10 - Clinical Note - M.D.
36.09/22/10 - Clinical Note - M.D.
37.10/05/10 - Utilization Review
38.10/13/10 - Letter - M.D.
39.10/25/10 - Utilization Review
40.***Official Disability Guidelines***

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury on xx/xx/xx when he was pushing a pallet jack and felt a pop in the right shoulder.

An MRI of the right shoulder performed 04/16/09 demonstrated small joint effusion with large amount of fluid in the subscapularis bursa which could represent bursitis. There was a full thickness tear without retraction of the supraspinatus tendon. There were acromioclavicular hypertrophic changes without rotator cuff impingement. There was a degenerative subchondral cyst in the humeral head. There was thinning of the glenoid labrum with suggestion of tear and fraying of the superior margin.

The employee saw Dr. with complaints of right shoulder pain. Physical examination of the right shoulder revealed forward flexion to 70 degrees, abduction to 70 degrees, and restricted internal rotation. The employee was only able to touch the lower spinous processes with the thumb. External rotation strength was 5/5. The employee was neurovascularly intact distally. There was no winging of the scapula noted. Radiographs of the right shoulder demonstrated no significant abnormalities. The employee was assessed with right shoulder rotator cuff tendonitis. The employee was prescribed Ketoprofen 6% cream.

The employee underwent open subacromial decompression of the right shoulder with excision of the CA ligament on 05/20/09.

A right shoulder arthrogram was performed on 07/16/09 without complication. An MR arthrogram of the right shoulder performed 07/16/09 demonstrated no evidence of rotator cuff tear. There was a tear of the superior glenoid labrum.

The employee underwent right stellate ganglion sympathetic block under fluoroscopic guidance on 10/06/09.

Electrodiagnostic studies performed 11/05/09 revealed evidence of carpal tunnel syndrome. There was mild delay of the ulnar sensory, indicating a possibility of a mild neuropathy.

The employee saw Dr. on 12/10/09 with complaints of right shoulder pain. The employee reported little benefit from the stellate block. Physical examination of the right shoulder revealed forward flexion to 120 degrees and abduction to 70 degrees. There was some swelling of the right hand. There was tenderness to the anterior and lateral shoulder. There was no erythema or warmth. The employee was referred for second opinion.

A Three Phase Bone Scan of the right shoulder performed 01/13/10 demonstrated abnormal activity in the right acromioclavicular joint, possibly related to status post acromioplasty. There was abnormal activity in the medial aspect of the right knee and the left ankle, possibly secondary to osteoarthritis. There was abnormal activity in the big toe, possibly secondary to gout or osteoarthritis.

The employee saw Dr. on 02/25/10 with continued pain complaints. Physical examination of the right shoulder revealed forward flexion to 100 degrees and abduction to 50 degrees. Examination of the skin demonstrated no rashes, swelling, erythema, warmth, or skin changes. There was no hypersensitivity. There were no sweat pattern changes. The employee was assessed with right shoulder impingement syndrome, right arm pain, and right carpal tunnel syndrome. The employee was recommended for a pain management program.

The employee saw Dr. on 04/06/10. The note stated the employee completed ten sessions of a pain management program, but his symptoms persisted. Physical examination revealed trembling with palpation of the hand. There was slight swelling to the arm and tenderness to the shoulder. Forward flexion was to 100 degrees and abduction was to 50 degrees. External rotation was to 40 degrees. The employee was recommended to continue his home exercises.

The employee saw Dr. on 05/19/10 with complaints of right shoulder pain. Physical examination of the right shoulder revealed incongruity of the shoulder to the right side due to loss of musculature of the deltoid and trapezius. There was limited active range of motion. There was passive abduction to 60 to 70 degrees, external rotation to 40 degrees, and internal rotation to 10 to 15 degrees. There was no weakness with internal rotation. Radiographs demonstrated satisfactory maintenance of the outlet. There was mild disused osteopenia. There was no evidence of fracture or dislocation. The employee was assessed with rotator cuff sprain, rotator cuff syndrome, and adhesive capsulitis. The employee was recommended for arthroscopy of the right shoulder with possible open repair of the rotator cuff.

The employee underwent right shoulder diagnostic arthroscopy with revision of repair of chronic right rotator cuff tear with acromioplasty on 06/24/10.

The employee underwent 7 physical therapy sessions from 07/15/10 through 08/02/10.

The employee saw Dr. on 08/04/10 with complaints of right shoulder pain. There was limited range of motion of the right shoulder with significant discomfort. Abduction was to 20 degrees. The employee was prescribed a Medrol Dosepak. If no improvement, the employee would be scheduled for a block and possible repeat manipulation under anesthesia.

The employee saw Dr. on 08/11/10. The employee reported no improvement with Medrol Dosepak. Physical examination revealed swelling of the right hand. There was significant pain in the right shoulder out of proportion with his motion. The employee was referred for evaluation of possible reflex sympathetic dystrophy and pain control.

The employee saw Dr. on 09/15/10 with complaints of right shoulder pain. Physical examination revealed significant discomfort in the shoulder with any motion. Strength could not be tested due to pain. There was significant swelling in the hand distally. The wounds were well-healed without evidence of infection. The note stated the employee was scheduled for a second block. The first block did not help with the employee's condition. If no improvement, the employee would be recommended for repeat radiographs and MRI of the shoulder.

The employee saw Dr. on 09/20/10 with complaints of right shoulder pain. The employee described throbbing and spasming. The pain worsened with movement of the arm. The employee reported poor sleep due to pain. Prior interventions included therapy, acupuncture, psychology, TENS unit, and a chronic pain program. Physical examination of the right shoulder revealed swelling to the right upper extremity. The employee was currently suffering from allodynia and hyperesthesia as well as pain out of proportion to the initial injury. There was decreased function. The employee was

assessed with complex regional pain syndrome Type I of the right upper extremity, chronic intractable pain syndrome, chronic opioid use, and shoulder pain. The employee was prescribed Gabapentin, Skelaxin, and Hydrocodone 10/325mg. The employee was recommended for right-sided stellate ganglion nerve root block with fluoroscopy.

The employee saw Dr. on 09/22/10 with complaints of right shoulder pain. The employee reported limited range of motion of the right shoulder with pain. Physical examination revealed decreased swelling of the hand. There was pain with any motion. There was weakness with internal and external rotation. The employee was assessed with rotator cuff sprain, rotator cuff syndrome, shoulder joint pain, and adhesive capsulitis of the shoulder. The employee was recommended for MRI of the right shoulder.

The request for right stellate ganglion nerve block with fluoroscopy was denied by utilization review on 10/05/10 due to lack of documentation to support the requested procedure to be one of medical necessity for the described medical situation.

A letter by Dr. dated 10/13/10 requested an appeal of the denial of the right stellate ganglion block. The letter stated the employee had good pain relief from the initial two procedures for which a third has been requested.

The request for right stellate ganglion nerve block with fluoroscopy was denied by utilization review on 10/25/10 due to lack of benefit from a prior stellate ganglion block performed in 2009. There were no stigmata of a complex regional pain syndrome. The bone scan of the body did not show findings of the upper extremity to suggest complex regional pain syndrome.

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

The requested right stellate ganglion nerve block is not supported by the clinical documentation provided for review. Based on review of the clinical notes provided, there is insufficient objective evidence of CRPS to warrant the requested nerve block. The employee does not demonstrate examination evidence of allodynia, hyperhidrosis, trophic skin changes, or hair loss typically seen in patients with CRPS. The employee's bone scan was negative for any findings consistent with possible CRPS. Additionally the employee was noted to have had previous stellate ganglion blocks for the right upper extremity with no documented improvement in pain scores or functional improvement. Additional injections would not be warranted per current evidence-based guidelines recommendations.

As the requested block is not supported by the clinical records provided and the clinical records do not meet guideline recommendations for the procedure, medical necessity is not supported.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

Official Disability Guidelines, Online Version, Pain Chapter