

SENT VIA EMAIL OR FAX ON
Dec/13/2010

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Stellale Ganglion Block Anesthesia

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

Medical physician Board-certified in Physical Medicine and Rehabilitation.

Medical Director of Rehabilitation Medicine.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 10/14/10 and 11/3/10

Dr. 9/7/10 thru 11/11/10

XR Wrist 12/11/09

Dr. 11/11/09

PATIENT CLINICAL HISTORY SUMMARY

This claimant has a date of birth of xx/xx/xx. He reported an injury xx/xx/xx. He struck his hand causing a laceration. He has had left upper extremity pain. He has numbness to the left upper extremity, hyperhidrosis and allodynia. He has had PT, injections to the hand and medications. He uses amitriptyline, hydrocodone and chlorzoxiprone. He has tried Lyrica and Cymbalta and they were not helpful. He complains of painful swollen joints and skin discoloration. He has been working. A 12/11/2009 x-ray of the hand showed a small foreign body near the thumb.

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

The ODG guidelines state there is limited evidence to support this procedure. It should be used in complex regional pain syndrome. It can be used for diagnosis and treatment of

sympathetic pain

This claimant does have swelling and mottling of the upper extremity. There is also evidence of a foreign body on x-ray. The notes do not indicate that this has been addressed. A foreign body could be contributing to the findings reported on examination and in the review of symptoms

SGB is not medically necessary until all other possible diagnoses are explored.

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

ACOEM-AMERICA 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)