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### Notice of Independent Review Decision

**DATE OF REVIEW:** 12/30/09

**IRO CASE #:**

#### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Radiofrequency ablation w/wo radiologic monitoring, fluoro guidance and localization of needle and need placement, therapeutic, prophylactic or diagnostic injection (64680, 77003, 77002, 97372)

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

Certified by The American Board of Physical Medicine and Rehabilitation

#### **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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
Xx/xx/xx	YMLC02452	Prospective	719.41	64680	Upheld

#### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician visit notes dated 11/10/09, 10/6/09, 7/9/09, 5/28/09, 4/23/09, 2/19/09  
Operative Report dated 2/9/09

#### **PATIENT CLINICAL HISTORY:**

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This is patient with a date of injury of xx/xx/xx. A prior stellate ganglion block had been completed on February 9, 2009. The pain complaints returned and the efficacy of the injection was not noted. The initial request for this injection was not certified. Upon reconsideration, the medical necessity was not established to the Reviewer's standards. There was no procedure note to support the request.

There is a November 20, 2009 note from the treating physician reporting that the injured employee "has been compliant" with conservative care, and that the injured employee "did very well with rhizotomy approximately xxxx". The prior progress note indicates good range of motion and no specific functional losses. The physician was "unsatisfied with his response" and felt that there was sympathetic mediated pain. Another physician noted an increase in wrist pain and noted it to be sympathetic wrist pain.

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

The Reviewer noted that, as noted in the Pain Chapter in the Official Disability Guidelines (updated December 8, 2009) this type of procedure is "not recommended. The practice of surgical and chemical sympathectomy is based on poor quality evidence, uncontrolled studies and personal experience. Furthermore, complications of the procedure may be significant in terms of both worsening the pain or producing a new pain syndrome; and abnormal forms of sweating (compensatory hyperhidrosis and pathological gustatory sweating). Therefore, more clinical trials of sympathectomy are required to establish the overall effectiveness and potential risks of the procedure. (Furlan, 2000) Mailis-Cochrane, 2003) Sympathectomy is destruction of part of the sympathetic nervous system and it is not generally accepted or widely used. Long-term success with this pain relief treatment is poor. Indications: Single extremity CRPS-I; distal pain only (should not be done if the proximal extremity is involved). Local anesthetic Stellate Ganglion Block of Lumbar Sympathetic Block consistently gives 90-100 percent relief each time a technically good block is performed (with measure rise in temperature). The procedure may be considered for individuals who have limited duration of relief from blocks. Permanent neurological complications are common (State, 2002)"

Therefore, in the Reviewer's opinion, based on the lack of specific documentation to substantiate the procedure, this request is not supported or considered medically necessary.

### **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)