



Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 5/7/10

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for acupuncture x 4 visits (99212, 97810).

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

Texas licensed chiropractor

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for acupuncture x 4 visits (99212, 97810).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Company Request for IRO dated 4/22/10.
2. Pre-Authorization Determination dated 4/19/10, 3/30/10, 1/21/09, 12/12/08.
3. Denial Appeal Letter dated 4/12/10.
4. Progress Note dated 3/29/10, 3/1/10, 12/3/09, 8/31/09, 7/27/09, 4/6/09, 3/9/09m 2/9/09.
5. Health Insurance Claim Form dated 3/23/10, 3/10/10, 8/17/09.
6. Texas Worker's Compensation Work Status Report dated 3/22/10, 3/10/10, 12/28/09, 8/28/09, 6/15/09, 4/9/09, 2/23/09, 12/4/08, 11/20/08, 11/14/08, 11/11/08, 9/18/08, 8/4/08, 7/17/08, 5/8/08, 3/31/08, 3/10/08, 2/1/08, 1/18/08, 1/9/08.
7. Functional Abilities Evaluation dated 3/23/10.
8. Follow-Up Visit dated 3/22/10, 3/2/10, 12/28/09, 11/18/09, 6/15/09, 4/9/09, 3/5/09, 2/23/09, 2/5/09, 1/5/09, 9/18/08, 7/17/08, 5/8/08, 3/31/08, 3/10/08, 2/1/08.
9. Report of Medical Evaluation dated 3/10/10, 4/13/09, 8/10/08, 8/4/08, 4/11/08.
10. History and Physical dated 3/10/10, 4/13/09, 1/19/09, 8/4/08.
11. S.O.A.P. Notes dated 3/9/10, 3/2/10, 2/18/09, 2/16/09, 2/9/10, 2/3/10, 2/1/10, 1/30/09, 1/22/09, 1/2/09, 12/29/08, 12/24/08, 12/22/08, 12/18/08, 12/16/08.
12. Operative Report dated 6/23/09, 6/16/09, 5/1/09, 3/31/09, 3/3/09, 2/3/09, 11/18/08.
13. Anesthesia Record dated 6/23/09, 5/1/09, 3/31/09, 3/3/09, 2/3/09.
14. Elbow Evaluation dated 2/20/09, 2/6/09, 1/7/09, 12/11/08.
15. Prescription Form dated 2/6/09.
16. Physical Therapy Referral dated 1/5/09.
17. Post-Operative Note dated 11/21/08.
18. Post-Op Physician Orders dated 11/20/08.
19. Pre-Op Testing and Day of Surgery Orders dated 11/18/08.
20. Post-Op Procedure/Post Sedation Orders dated 11/18/08.
21. Assessment and Orders dated 11/18/08.
22. Physician's Orders dated 11/18/08.
23. Initial Nursing Assessment dated 11/18/08.
24. Patient Progress Notes dated 11/18/08.
25. PACU-Post Anesthesia/Recovery Record dated 11/18/08.
26. Peer to Peer Notes dated 10/6/08.
27. Blood Test Results dated 11/17/08.
28. EMG/NCV Findings Report dated 3/25/08.
29. Left Elbow (w/o contrast) MRI Report dated 1/23/08.
30. Examination Record/Notes, unspecified date.

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Gender: Male

Diagnosis: Left elbow contusion and left traumatic ulnar neuritis.

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

This male was involved in a work related injury on xx/xx/xx. He initially presented to the local industrial clinic where he was evaluated, prescribed medication, and placed on modified duty. An MRI of the left elbow, dated 1/23/08, was normal. He then sought an orthopedic consultation with Dr. who diagnosed the claimant with left elbow contusion and left traumatic ulnar neuritis. The recommendation was for an electromyogram (EMG) if the pain persisted. On 3/25/08, he underwent EMG/nerve conduction velocity (NCV) studies of the upper extremities which revealed findings suggestive of chronic left ulnar nerve irritation. He continued to be evaluated by the orthopedist over the next several months while on modified duty. On 8/4/08, he underwent a designated physician evaluation with Dr. an orthopedist, who opined that the claimant had not reached maximum medical improvement (MMI). On 11/18/08, the claimant underwent left ulnar nerve anterior subcutaneous transposition surgery. This was followed by a course of occupational therapy. On 1/19/09, he was referred to the office of Dr., pain management specialist, for an evaluation. A recommendation was made for diagnostic and therapeutic stellate ganglion blocks. On 2/3/09, 3/3/09, and 3/31/09, the claimant underwent left stellate ganglion block performed by Dr. M.D., for the diagnosis of complex regional pain syndrome (CRPS) of the left upper extremity and left ulnar neuralgia. On 4/13/09, he underwent a follow-up designated doctor exam (DDE) with who again opined that the claimant was not at MMI. On 5/1/09, 6/16/09, and 6/23/09, the claimant underwent additional stellate ganglion blocks. On 7/27/09, he was evaluated by Dr.. At that time, the claimant noted overall improvement but began to note cervical pain. He also began to note pain around the left shoulder blade which radiated into the left arm at 6-7/10 on the visual analogue scale. He opined that he was "afraid the cervical pain may be fitting into the RSD pain and keep the autonomic nervous system inflamed and irritated." It was opined that the claimant may require an epidural injection. He further opined that the stellate ganglion blocks were no longer providing benefit and would be discontinued. On 8/31/09, the claimant was reevaluated by Dr., who indicated that the claimant "has been doing fairly well and most of the sympathetically mediated symptoms have calmed down." The recommendation was to continue Lyrica. A follow-up examination, on 12/3/09, noted that the claimant reported "his pain in the hand has completely improved. He still had some allodynia and hypersensitivity on the inner side of the left elbow." On 12/28/09, a reevaluation, by Dr., noted that the claimant still had

hypersensitivity to the area. He opined that the claimant "may be a candidate for acupuncture as he continues to have significant pain." On 2/1/10, the claimant presented to the office of DC, upon referral from his orthopedic surgeon, for a course of acupuncture. 4 visits of acupuncture were authorized. The claimant received a total of 8 acupuncture treatments through 3/11/10. On 3/10/10, he underwent a follow-up DDE with Dr.. It was opined that the claimant was at MMI. The evaluator opined that "his statutory dated 4/10/2010, and I am seeing him one-month prior to that. I do not anticipate that he will improve anymore between now and then, although he is undergoing acupuncture treatments at that time." The evaluator further opined that "there was a question whether the acupuncture treatments were working." He further indicated "there may be other injections recommended by Dr. but they are not likely to significantly change his state between now and his statutory date." A functional capacity evaluation was performed on 3/23/10, as part of the DDE. At that time, the claimant noted pain levels of 8/10 on the visual analogue scale. It was determined that the claimant was able to function at a physical demand capacity of medium. The job had a heavy physical demand level (PDL). Dr. reevaluated the claimant on 3/29/10. It was noted that the claimant continued to have constant pain at 6-7/10 and became worse with physical activity. It was noted that "the patient has been seeing an acupuncturist who have done the 8 sessions that according to the patient did help some of his pain." The recommendation was for "continuing chiropractor treatment along with the Lyrica that will keep the pain under control." A request for 4 additional acupuncture treatments was submitted. This was denied by peer review. This was also denied on appeal. The purpose of this review is to determine the medical necessity for the requested for additional acupuncture treatments.

The medical necessity for the requested for additional acupuncture treatments was established. The previous reviewers utilized the acupuncture guidelines from the elbow chapter which indicate: "Initial trial of 3-4 visits over 2 weeks; With evidence of objective functional improvement of VAS score, treatment can be approved up to a total of 8 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy.)" The claimant received 8 treatments with evidence of slight improvement. His grip strength had increased and there was a slight reduction in pain. However, given his presenting complaints primarily of pain, the pain chapter would be a more appropriate reference. It gives the following recommendations regarding acupuncture for pain: "Initial trial of 3-4 visits over 2 weeks; With evidence of reduced pain, medication use and objective functional improvement, total of up to 8-12 visits over 4-6 weeks." The claimant received 8 treatments with mild improvement. Dr. evaluated the claimant, on 3/29/10, who noted that the acupuncture "did help some of his pain." Given the severity and length of time of this claimant's complaints and the response to the initial course of 8 acupuncture treatments, the ODG would support the requested 4 additional treatments. Therefore, the previous adverse determination is overturned.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
 - Official Disability Guidelines (ODG), Treatment Index, 8th Edition (web), 2010, Elbow & Pain chapters – Acupuncture.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).