



Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 09/20/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left Stellate Ganglion Block of the Left Shoulder

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

Board Certified in 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)

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.

Left Stellate Ganglion Block of the Left Shoulder – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Initial Office Visit, , M.D., 10/02/09
- Office Visit, Dr., 10/16/09, 10/19/09, 10/27/09, 10/29/09
- TWCC 73, Dr., 11/24/09
- Office Evaluation, M.D., 12/17/09
- MRI Left Shoulder, , M.D., 12/23/09
- Evaluation, , D.O., 01/07/10
- Physical Therapy Sessions, Excel Therapy, 01/12/10, 01/18/10, 01/19/10, 02/01/10, 02/10/10, 02/15/10, 02/16/10
- Evaluation, , D.O., 01/20/10
- Progress Report, Dr., 02/17/10, 03/10/10
- MRI Arthrogram Left Shoulder, , M.D., 03/04/10
- Designated Doctor Evaluation (DDE), , M.D., 04/28/10
- Pain Management Evaluation, , M.D., 04/29/10
- Therapy Notes, , D.C., 05/24/10, 05/26/10, 06/01/10, 06/03/10, 06/04/10, 06/07/10, 06/28/10, 07/07/10, 07/16/10, 07/21/10
- Required Medical Evaluation (RME), , D.C., 06/17/10
- TWCC 60, Dr., 06/17/10
- Follow Up, Dr., 06/25/10
- TWCC 73, Dr., 07/13/10
- Denial Letter, 08/12/10, 08/26/10
- DDE, Dr., 08/18/10
- Correspondence, attorney, 08/19/10

- Carrier Submission, Law Offices, 09/03/10
- The ODG Guidelines were provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient injured his left shoulder on xx/xx/xx while pulling a fastener from a roof, hitting himself with a hammer. An MRI of the left shoulder showed mild tendinopathy of the infraspinatus tendon and no discrete labral tear was indentified. The patient attended approximately seven sessions of physical therapy. An MRI arthrogram of the left shoulder was then performed which showed outlet impingement findings with mild bursal surface supraspinatus fraying. After a pain management consultation, he was placed on Neurontin 300 mg, which was to be titrated to effectiveness for the treatment of the neuropathic component of his pain. A left stellate ganglion block was requested at that time. A follow up with pain management resulted in an increase of Neurontin to 600 mg three times per day. He was diagnosed with left shoulder pain, evidence of left upper extremity neuropathic pain and torn left rotator cuff tendon. He was also provided with Lidoderm patches. The left stellate ganglion block was once again requested.

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

The left stellate ganglion block to the left shoulder is not reasonable and necessary. Documentation provided does not provide any evidence consistent with the diagnosis of CRPS of the left shoulder. Evidence-based criteria contained in the ODG as well as the American Medical Association Guide to the Evaluation of Permanent Impairment list the criteria for diagnosis of possible CRPS. Pain out of proportion to physical findings is the only criteria that this individual meets based upon provided records. Therefore, he does not meet evidence-based criteria for possible CRPS.

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)
- AMA GUIDES 5TH EDITION