

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: April 7, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient left stellate ganglion block.

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

M.D., 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)

The requested service, outpatient left stellate ganglion block, is medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO).
3. Notice of Assignment of Independent Review Organization.
4. Medical records from MD dated 1/11/11, 1/18/11 and 2/28/11.
5. Medical records from Physical Therapy Associates dated 7/7/10.
6. Medical records from MD dated 4/7/10 through 3/21/11.
7. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx while climbing up a ladder. The patient is status post left shoulder excision of the distal clavicle, acromioplasty, and rotator cuff repair on 5/13/10. He also underwent a labral repair on 9/10/10. The patient has participated in 35 post-operative physical therapy sessions as of 12/29/10. The provider notes indicate that the patient presented with continued complaints of severe, excruciating and intractable pain to the left shoulder that was extending into the upper extremity entirely. The provider additionally noted that the patient's left hand and wrist showed significant swelling and the allodynia and mottling were significantly increased. Also noted were significant guarding and limitation in the patient's range of motion to the left upper extremity and shoulder when compared to the right. The provider recommended a stellate ganglion block on the left side. The URA states that stellate ganglion blocks are generally recommended for diagnosis and therapy for complex regional pain syndrome (CRPS). The URA additionally states that that the requested stellate ganglion block is not indicated as the clinical evaluation does not reveal objective evidence of allodynia, skin mottling, or temperature changes that are typically associated with CRPS.

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

The patient's treating physicians have clearly outlined the patient's past history and the treatment he has received. Based on this documentation, the patient meets criteria for treatment with left stellate ganglion block. The Official Disability Guidelines (ODG) support the use of sympathetic blocks for treatment of CRPS. The submitted documentation does include confirmatory evidence of CRPS. The physician noted that the patient's left hand and wrist showed significant swelling, and allodynia and mottling were significantly increased. According to ODG, "Edema control may also be required (elevation, retrograde sympathetic blocks, diuretics and adrenoceptor blockers when sympathetically maintained pain-SMP is present)." The patient has had two shoulder surgeries, physical therapy, medications and work restrictions without adequate relief. The use of left stellate ganglion blocks is medically reasonable and 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)