

SENT VIA EMAIL OR FAX ON
Jan/30/2012

True Resolutions Inc.

An Independent Review Organization
500 E. 4th St., PMB 352
Austin, TX 78701
Phone: (214) 717-4260
Fax: (214) 276-1904
Email: rm@trueresolutionsinc.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/26/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Left Stellate Ganglion Block under Fluoroscopy with Anesthesia

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

Anesthesiology/Pain Management

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

UR determination 12/09/11

UR reconsideration determination 12/21/11

Preauthorization request 12/05/11

Preauthorization reconsideration request undated

MRI report left wrist 10/12/11

Office notes Orthopedic Surgery Group 08/19/11-11/15/11

Therapy daily progress notes and reevaluation 09/13/11-11/17/11

Electrodiagnostic report 10/31/11

Appeal letter M.D. 12/13/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who was injured on xx/xx/xx when she slipped and fell on outstretched arm. X-rays of elbow were noted to reveal a radial neck fracture. X-rays of wrist demonstrated osteopenia but no obvious acute fractures. MRI of left wrist on 10/12/11 was

reported as normal exam. The patient was treated with physical therapy and medications but continued to complain of pain in wrist as well as medial elbow pain. Electrodiagnostic testing was performed on 10/31/11 and revealed no evidence of left medial ulnar radial neuropathy (normal study). There was no evidence of active denervation based on needle EMG examination. On examination the claimant had pain with any motion of wrist of forearm. She had diffuse swelling and shiny appearance of skin possibly consistent with development of regional pain syndrome / RSD. She was recommended to undergo stellate ganglion block.

Per UR determination dated 12/09/11, request for left stellate ganglion block under fluoroscopy with anesthesia was non-certified. It was noted the claimant was diagnosed with RSD of left upper extremity per medical report dated 11/15/11. Examination revealed diffuse pain throughout the upper extremity, swelling, and decreased range of motion of fingers. It was noted there is no objective documentation provided with regard to failure of claimant to respond to other conservative measures such as oral pharmacotherapy. It was noted current evidence based guidelines indicate there are limited studies to support benefits of requested injection and request is not substantiated at this time.

A reconsideration request of previous non-certification was reviewed on 12/21/11 and the request for left stellate ganglion block under fluoroscopy with anesthesia was non-certified. It was noted the claimant experiences left upper extremity pain. On physical examination, there is note of allodynia, hyperesthesia, pseudo motor changes, mottling and decreased function of the left upper extremity. It is noted as per referenced guidelines that there are limited studies to support the requested procedure. If it is to be performed anyway, the recent medicals submitted for review dated 11/15/11 and 12/13/11 did not contain comprehensive objective findings, such as a detailed orthopedic and neuromotor examination that substantiate the necessity of the requested procedure. Furthermore, there was no objective documentation of the failure of trial of conservative treatment, such as physical therapy and optimization of pharmacotherapy. As such, the previous non-certification of the medical necessity of this request for a left stellate ganglion block is upheld.

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

Based on the clinical information provided, the request for left stellate ganglion block under fluoroscopy with anesthesia is supported as medically necessary. The claimant is noted to have sustained an injury secondary to fall on outstretched arm resulting in radial neck fracture. The claimant subsequently developed CRPS / RSD of left upper extremity. Examination findings noted classic signs of CRPS with pain out of proportion of injury, allodynia, hyperesthesia, pseudo motor changes and mottling and decreased function. EMG noted RSD would definitely be differential diagnosis in this case. Records also reflect the claimant has been treated conservatively with physical therapy and medications including Ibuprofen, nonsteroidal anti-inflammatories and opioid Hydrocodone. As such, a diagnostic left stellate ganglion block with fluoroscopy and anesthesia is indicated as medically necessary, and previous denials should be overturned on IRO.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES