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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jun/04/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OP Thoracic Sympathetic Ganglion Block T2, T3 left side

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

Board Certified Anesthesiologist

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury to her left upper extremity. The initial injury occurred on xx/xx/xx when she had a trip and fall. The clinical note dated xx/xx/xx indicates the patient complaining of left upper extremity pain specifically at the shoulder and wrist. The patient also reported intermittent tightness with catching, aching, spasming, and weakness. The patient rated the pain as 0-8/10. The note indicates the patient's activities of daily living had decreased. The note indicates the patient presenting in severe distress. Upon exam, the patient demonstrated 2-3/5 strength throughout the left upper extremity. No sensory or dermatomal deficits were identified. Reflexes presented as normal at the brachial radialis, biceps, and triceps. The x-rays of the left elbow dated xx/xx/xx indicate the patient having previously undergone an ORIF at the distal left humerus and the proximal ulna. The presence of the internal fixation hardware was identified. The clinical note dated 12/23/13 indicates the patient stating the initial injury occurred when she caught her foot in a cable resulting in the fall. The clinical note dated 03/20/14 indicates the patient rating her pain at that time as 3-9/10. The patient continued with significant strength deficits throughout the left upper extremity that were rated as 2-3/5. The note indicates the patient having been diagnosed with CRPS type 2 in the left upper extremity. The patient was identified as having multiple triggers in all muscles along with atrophy at the left upper extremity. The patient presented with a somewhat flaccid tone and was unable to extend the elbow. The patient also lacked 30 degrees of flexion.

The utilization reviews dated 03/28/14 and 04/16/14 resulted in a denial for a sympathetic block as no information was submitted confirming that all other diagnoses had been ruled out. Additionally, no information was submitted regarding the patient's Budapest criteria score.

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

The documentation indicates the patient complaining of left upper extremity pain. The most recent clinical note indicates the patient showing left elbow range of motion deficits. There is an indication that the patient has been diagnosed with CRPS 2/RSD in the left upper extremity. The patient is also identified as being status post ORIF at the distal humerus and proximal ulna on the left. However, no information was submitted regarding the patient's Budapest score. Additionally, no information was submitted confirming the CRPS/RSD diagnoses. Given the lack of any Budapest criteria score confirming the patient's CRPS/RSD, this request is not indicated. As such, it is the opinion of this reviewer that the request for a thoracic sympathetic ganglion block at T2 and T3 on the left is not recommended as medically necessary.

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

ACOEM-AMERICA 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)