

October 1, 2003

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TWCC Medical Dispute Resolution
MS-48
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MDR Tracking #: M2-04-0017-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Osteopathy with a specialty in Pain Management and board certification in Anesthesiology. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was injured on ___ as she was about to sit on a chair. She held on to the edge of the counter and felt like she was about to fall, grabbing the counter and feeling a sudden jerk in her right hand and shoulder. She did not seek medical attention for a couple of weeks, after which time she was extensively evaluated by chiropractors and orthopedic surgeons.

Electrodiagnostic studies revealed evidence of mild to moderate carpal tunnel syndrome. The patient had multiple physical examinations by ___ and ___ with no documentation of any signs of autonomic dysfunction, RSD, or complex regional pain syndrome (CRPS). A triple-phase bone scan was performed on 10/16/02 that showed no findings consistent with RSD or CRPS.

The patient was referred to ___ for initial consultation on 10/31/02 by ___. She complained of pain most severe at the right shoulder, radiating into the entire right upper extremity as well as the right shoulder blade and intrascapular region. She also complained of frequent headaches, numbness and tingling in her right hand, and weakness of the right hand. She denied any temperature changes or hyperhidrosis.

___ reviewed the studies that had been performed on the patient, including the negative bone scan. ___ physical examination documented no signs of autonomic dysfunction involving the right upper extremity. He documented minimally decreased range of motion of the right shoulder, mild swelling in the dorsum of the right hand, no discoloration or hyperhidrosis of either upper extremity, and minimal, clinically insignificant temperature differences between the right forearm, hand, and index finger compared to the left. Skin sensation was diminished in the right median and ulnar nerve distributions of the right upper extremity. ___ requested authorization for BOTOX injections for treatment of a diagnosis of myofascial pain syndrome, which was denied.

___ subsequently had electrodiagnostic testing by ___ on 1/14/03 that demonstrated mild to moderate right carpal tunnel syndrome, with no other abnormalities. ___ then requested a right stellate ganglion block that was denied after a Designated Doctor Evaluation on 7/31/03 performed by ___.

In that evaluation, ___ documented a physical examination revealing no evidence of hair growth change, skin change, nail bed changes, temperature differential, or allodynia, as well as no skin discoloration or edema in any of the digits of the right hand relative to the left. She documented fairly full range of motion of the right shoulder in all planes, as well as wall press and bounce using fingertips from the wall, with no difficulty putting full pressure on her fingertips and wrists.

___ also documented her observation of the patient's ability to open and close passenger doors, pass items carried in her right arm into the vehicle without guarding or limitation, and full movement of the right upper extremity as the patient was observed leaving the clinic. ___ stated that this was in distinct contradiction to the patient's appearance to guard the right upper extremity and limited use during her examination. She stated that the patient had a "seemingly inconsequential event on ___ and that there was no consistent or credible medical evidence to support a diagnosis of reflex sympathetic dystrophy, or RSD.

On 8/8/03 ___ wrote a letter of appeal, again requesting performance of the right stellate ganglion block. His justification was his documentation of swelling and temperature changes of the right hand, which he termed "strongly suggestive" of autonomic dysfunction and possible CRPS Type 1. The carrier has denied approval of the right stellate ganglion block as medically unnecessary.

REQUESTED SERVICE

Lumbar Stellate Ganglion Block is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

All physical examinations that have been performed on this patient by multiple physicians have failed to document any significant evidence of autonomic dysfunction or signs of RSD or CRPS. The presence of swelling and minimal temperature differences is not a sufficient physical finding to justify either a diagnosis of RSD or CRPS, or to necessitate investigation of such a possible diagnosis.

There are at least eight physical examination criteria that normally accompany reflex sympathetic dystrophy/CRPS. In this case, the only physical examination criteria that is met is that of swelling, which is clearly such a nonspecific examination finding as to be completely non-diagnostic and insufficient to necessitate any further testing, including stellate ganglion block. This patient has never demonstrated color changes or significant temperature changes, allodynia, hypersensitivity, abnormal hair or skin appearance, joint stiffness, or excessive swelling. There is simply insufficient symptomatology and physical examination evidence to justify medical necessity for stellate ganglion block and, therefore, the procedure is not medically reasonable or necessary for treatment or evaluation of the patient's compensable injury of ____, which as described by ____ was nothing more than a seemingly insignificant event causing no trauma, damage, injury, or harm to any part of the patient's body, including any part of the right upper extremity.

____ evaluation on 7/31/03 is comprehensive, complete, and quite illustrative of the absence of any credible evidence of signs or symptoms of RSD, and appropriately denies the medical necessity for right stellate ganglion block.

____ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ____ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ____, I certify that there is no known conflict between the reviewer, ____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

____ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 1st day of October 2003.