

December 23, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-04-0483-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the \_\_\_ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in anesthesiology. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 47 year-old male who sustained a work related injury on \_\_\_. The patient reported that while at work as a welder, he was pulling welder's lead when he sustained a twisting injury to the right index finger. The patient was evaluated in an emergency room where he was diagnosed as having a fracture. The patient was splinted and after removal of the splint was buddy wrapped, and received physical therapy and oral pain medications. On 8/5/03 the patient underwent a right index finger digital block with local anesthetics and steroids. Diagnoses for this patient are healed proximal phalanx fracture with residual stiffness/right index and possible complex regional pain syndrome.

### Requested Services

Outpatient procedure for right stellate ganglion block under fluoroscopy to be performed at \_\_\_.

### Decision

The Carrier's denial of authorization for the requested services is upheld.

### Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that this case concerns a 47 year-old male who sustained a work related injury to his right index finger. The \_\_\_ physician reviewer indicated that the patient was diagnosed with a fracture of the right index finger. The \_\_\_ physician reviewer noted that the patient's finger was initially treated with splinting followed by buddy taping. The \_\_\_ physician reviewer explained that the patient was then treated with two months of physical therapy for continued complaints of pain caused by any activity using the right index finger.

The \_\_\_ physician reviewer noted that on 6/30/03 the patient was evaluated by orthopedics who determined that the patient could be experiencing residual stiffness in the finger joint and that the pain and swelling could indicated complex regional pain syndrome. The \_\_\_ physician reviewer also noted a pain management evaluation in 7/03 indicated that the diagnosis for this patient was chronic pain and paresthesias of the right index finger with digital neuralgia, and no signs or symptoms of complex regional pain syndrome. The \_\_\_ physician reviewer explained that the patient was started on Vioxx, Keppra and a right index regional block was performed in 8/03. However, the \_\_\_ physician reviewer indicated that the patient did not experience significant relief from the block and a stellate ganglion bock was then requested for treatment of presumed complex regional pain syndrome. The \_\_\_ physician reviewer explained that there is no documentation provided indicating the diagnosis of complex regional pain syndrome. The \_\_\_ physician reviewer indicated that the patient has been evaluated by orthopedics and pain management and that there have been no documented findings consistent with a sympathetically mediated process. The \_\_\_ physician reviewer explained that the orthopedic evaluation indicated residual joint stiffness as well as stiffness on the basis of probable extensor tendon adherence and intrinsic tightness. The \_\_\_ physician reviewer also explained that the patient has not responded to nerve block and there are minimal signs of autonomic dysfunction on exam. The \_\_\_ physician reviewer further explained that the pain management evaluation indicated the member did not have evidence of complex regional pain syndrome. Therefore, the \_\_\_ physician consultant concluded that the requested outpatient procedure for right stellate ganglion block under fluoroscopy to be performed at \_\_\_ is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this 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)** days of your receipt of this decision. (20 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)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

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

**A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 23<sup>rd</sup> day of December 2003.