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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
Dec/18/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient Right Stellate Ganglion Block with Fluoroscopy with sedation X 3 injection C Spine

A 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)

[X] Partially Overturned (Agree in part/Disagree in part)

Overturned: outpatient right stellate ganglion block with fluoroscopy and sedation x1

Upheld: outpatient right stellate ganglion block with fluoroscopy and sedation x3 injections

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO dated 11/28/12
Receipt of a request for IRO dated 11/28/12
Utilization review determination dated 09/21/12
Utilization review determination dated 11/13/12
Designated doctor report dated 10/10/11
DWC Form 69 dated 10/10/11
Clinical records dated 08/24/12, 09/12/12, and 10/16/12
Undated clinical note page 3 of 4

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who is reported to have sustained work-related injuries to his right thumb on xx/xx/xx. He is reported to have sustained a laceration which was subsequently sutured. He is reported to have had persistent pain and hyperesthesia that radiated up to the right forearm and shoulder area. He is reported to have had severe difficulty using the right hand. He was subsequently released to return to work.

The claimant was subsequently seen by a designated doctor on 10/10/11. These records

indicate that the claimant was treated conservatively with oral medications and injections. He was later recommended to undergo sympathetic blocks. He has undergone physical therapy. On physical examination he is reported to have severe hyperesthesia involving the entire right thumb, maximal over the dorsal and radial side up to the metacarpal phalangeal joints. The right thumb is noted to be very mildly swollen and slightly darker in color when compared to the left thumb. Palm is normal and symmetric on both sides. Motor strength is intact. Reflexes are intact. He was opined to have right thumb reflex sympathetic dystrophy. He was subsequently placed at MMI.

On 08/24/12, the claimant came under the care of. The claimant is noted to have had pain which radiates up the extremity into the elbow and now into the upper shoulder and neck areas. notes that the claimant has been seen by several physicians and the consensus is reflex sympathetic dystrophy. Current medications include Hydrocodone 5mg. On physical examination, he is noted to have an antalgic limp and gait. He has decreased range of motion of the neck and multiple areas of trigger points and tenderness throughout. He is reported to have complete hyperesthesia throughout the right upper extremity. There is allodynia to soft touch and passive range of motion throughout his right wrist, hand, forearm, and elbow with mild allodynia extending up into the shoulder area. His right hand is reported to be moist to touch with mottles skin appearance. Grip strength is graded as 3/5. Spurling's and Hoffman's tests are negative. Sensation is diminished in a non-segmental dermatomal fashion. The claimant was opined to have a complex regional pain syndrome and subsequently was recommended to undergo stellate ganglion blocks.

The initial review was performed on 09/21/12. non-certified the request for 3 stellate ganglion blocks. He noted that the clinical documentation submitted for review does indicate that the patient has a diagnosis of chronic regional pain syndrome. However, as the current request was for 3 injections, the request could not be supported at the time. The guidelines indicate that during initial diagnostic phase if pain relief is less than 50% and no further injections would be recommended. As such, the request for 3 blocks was not supported.

The appeal request was performed on 11/13/12. upheld the previous denial. He noted that the initial request was non-certified due to the lack of a documented initial test block. He noted that in the absence of data from a diagnostic block, the request for 3 stellate ganglion blocks would not meet ODG criteria and as such, could not be supported.

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

The request for an outpatient right stellate ganglion block with fluoroscopy and sedation x3 injections is partially overturned. This reviewer recommends an outpatient right stellate ganglion block with fluoroscopy and sedation x1. The submitted clinical records clearly indicate that the claimant has evidence of reflex sympathetic dystrophy. The claimant has yet to undergo a diagnostic stellate block which would be appropriate. Therefore, based on this data, a partial overturning is recommended. It is the opinion of this reviewer that the 1 stellate ganglion block is 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

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

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)