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An Independent Review Organization

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX XX Block

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|--|--------------------------------|
| <input checked="" type="checkbox"/> Overturned | Disagree |
| <input type="checkbox"/> Partially Overturned | Agree in part/Disagree in part |
| <input type="checkbox"/> Upheld | Agree |

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a now XXXX with an occupational claim from XXXX. The mechanism of injury was detailed as a XXXX. The current diagnoses were documented as pain in XX hand, pain in joints of XX hand, complex regional pain syndrome of XX XX lid, and chronic pain syndrome. Per the progress note dated XXXX the patient reported XX hand pain rated 6/10. The pain was described as achy, dull, stabbing, shooting, burning, and tingling and radiated up the XX arm into the XX shoulder and XX. The patient reported the XX hand and arm swell, feel colder than the left, and get red and purple. At times the hand was very sensitive to light touch and the functional use had decreased noticeably. The patient does wear a brace for protection. The patient had an injection in the carpal tunnel that caused a pain flare up. Patient reported taking XXXX for pain. On exam of the XX hand there was swelling with skin mottling in a sling. Atrophy was present in the shoulder and XX and XX was present. The skin was cool and mottled. There was limited range of motion and muscle tone and strength was 4/5. The patient was participating in physical therapy and there was improvement in function, decreased medication need, and pain relief from previous XX blocks. The duration of relief had been increasing but the symptoms had not resolved. The treatment plan included XX XX block. The previous denial denied the XX block as there was no evidence of increased tolerance of activity and touch or decreased as result of the prior blocks.

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

The Official Disability Guidelines recommend local anesthetic sympathetic blocks for limited, select cases. In the therapeutic phase repeat blocks should only be undertaken if there is evidence of increased range of motion, pain and medication use reduction, and increased tolerance of activity and touch (decreased XX) is documented to permit participation in physical therapy/ occupational therapy. The most recent follow up visit the patient reported XX hand pain rated 6/10. The patient reported the XX hand and arm swell, feel colder than the left, and get red and purple. On exam of the XX hand there was swelling with skin mottling in a sling. Atrophy was present in the shoulder and XX and XX was present. The patient was participating in physical therapy and there was improvement in function, decreased medication need, and pain relief from previous XX blocks. The duration of relief had been increasing but symptoms have not resolved.

Therefore, the request for XX XX block is medically necessary and therefore overturned.

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

MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Pain Chapter, CRPS, sympathetic blocks (therapeutic).