

FORTE NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 19, 2004

RE:

MDR Tracking #: M5-04-0077-01

IRO Certificate #: 5242

FORTE has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to FORTE for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

FORTE has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Submitted by Requester:

- 10/6/04 provider appeal/grievance request form from _____ which was in reference to the disputed services
- 10/4/04 note from _____ which served as a rationale letter for the medical necessity of the disputed services
- Usual notice of IRO assignment and pre-payment invoice
- 7/23/04 letter from _____ which served as a rationale letter for the medical necessity of the disputed services
- Prescription for a bone scan to “rule out reflex sympathetic dystrophy and/or any other pathology” from _____, orthopedist and surgeon for the claimant dated 8/22/03
- Three phase bone scan report of 9/2/03
- 8/7/03 chiropractic daily note which mentioned nothing about symptoms associated with reflex sympathetic dystrophy
- 9/22/04 note from _____, regarding a summary of the carrier’s position

Submitted by Respondent:

- 10/8/04 note from _____
- TWCC-21 report dated 2/9/04 from the carrier regarding the fact that they were accepting the claimant’s right wrist, arm and shoulder injury, yet they were disputing the extent of

the injury as it pertained to reflex sympathetic dystrophy or complex regional pain syndrome

- Chiropractic peer review from _____ dated 6/26/03
- Note from the carrier stating that _____, the designated doctor, felt that the diagnosis of reflex sympathetic dystrophy/complex regional pain syndrome was not related to the injury of 8/19/02
- Letter of clarification of 12/29/03 from _____
- TWCC-69 form of 10/24/03 from _____ stating the claimant was at MMI on that date with 5% whole body impairment rating
- Report of medical evaluation from _____ dated 10/24/03 along with the supplemental information and report regarding the claimant
- A range of motion study involving the wrist and spine dated 10/24/03
- Grip strength analysis dated 10/24/03
- Three phase bone scan report of 9/2/03
- 8/7/03 chiropractic note
- 8/22/03 prescription from _____
- Letter of 8/30/04 from _____ requesting payment on the disputed service
- Explanation of benefits regarding the disputed date of service

Clinical History

The claimant reported onset of right wrist and elbow pain during the normal course and scope of her employment on or about 8/19/02. The claimant stated the symptoms had been coming on for the last week or so prior to this date. The claimant reportedly claimed knee injury as well about 9 days later on 8/28/02. The claimant has undergone what has been documented to be extensive amounts of mostly unnecessary chiropractic management to no avail. She eventually underwent a carpal tunnel release surgery on 2/26/03 and the documentation suggests that she also had an ulnar nerve release surgery at the right elbow. There was a suggestion that the claimant may be developing reflex sympathetic dystrophy or complex regional pain syndrome and _____, the claimant's surgeon, as well as _____, the treating chiropractor, were requesting a bone scan to rule out these conditions. It was also suggested that a bone scan be done prior to the ulnar nerve release surgery. The claimant's neck has not been ruled compensable. It has been stated in a peer review report of 6/26/03 that the MRI involving the neck was essentially normal and that the claimant had insufficient electrodiagnostic evidence to support carpal tunnel syndrome as of 10/10/02.

Requested Service(s)

Diagnostic testing, CPT codes 78315, 78890 and 78990 denied by the carrier as unnecessary medical treatment and/or service per peer review. It appears that the peer review that is being referenced is the chiropractic peer review of 6/26/03 which was, of course, prior to the disputed date of service on 9/2/03.

Decision

I agree with the insurance carrier that the services in dispute were not medically necessary.

Rationale/Basis for Decision

Even though the peer review was performed prior to the date of service in dispute, there is or was lack of clinical information in the provided documentation to suggest there was clinical evidence of complex regional pain syndrome or reflex sympathetic dystrophy that would otherwise normally make a bone scan medically necessary. There was a total lack of documented evidence of abnormal sweat patterns, trophic skin changes, temperature changes and color changes, etc. in the clinical documentation that would warrant the bone scan. A 7/23/04 letter from _____ stated the claimant presented with symptoms of abnormal sweating, joint contracture and changes in skin texture; however, aside from this letter there is no clinical documentation in the concurrent clinical documentation to suggest that these symptoms were occurring. A chiropractic note of 8/7/03, which was the only chiropractic note provided for review, stated nothing about reflex sympathetic dystrophy or complex regional pain syndrome. There was no mention of any symptoms that would be remotely related to reflex sympathetic dystrophy or complex regional pain syndrome. The only documentation from _____ was in the form of a prescription for the bone scan to rule out reflex sympathetic dystrophy or other problems. In other words, _____ also did not provide any specific clinical information as to why he suspected reflex sympathetic dystrophy. Although a tri-phase bone scan is the diagnostic test of choice for ruling out complex regional pain syndrome or reflex sympathetic dystrophy, there was no documented clinical reason to perform the test in the first place. It has also been suggested that the bone scan was needed to rule out reflex sympathetic dystrophy prior to elbow release surgery. Despite the bone scan findings of “probable reflex sympathetic dystrophy”, the surgery was reportedly done anyway; therefore, I do not understand why the surgery proceeded despite the evidence of probable reflex sympathetic dystrophy. In this respect the test was pointless. The documentation also suggested that the claimant had many symptoms that were not even related to the injury and the designated doctor evaluation report was very suggestive that the claimant had mainly a subjective problem and that there was a lack of ongoing objective evidence of injury and there was absolutely no evidence in the opinion of the designated doctor to suggest the presence of reflex sympathetic dystrophy. In fact, the designated doctor stated that the reflex sympathetic dystrophy “was absolutely not present at this time and with no scientific basis whatsoever.” This was as of 10/24/03. The designated doctor further stated that the “examinee has no other problems except that she appears to be quite geared up to have more surgery and gives a history of elevated blood pressure for which she does not remember the name of the blood pressure medication she is taking”. It was also stated that “the examinee is complaining of a multiplicity of symptoms some of them not related to the surgery she had in the past”. The documentation suggests that she was just having general non-specified elbow and hand pain that in no way suggested the presence of reflex sympathetic dystrophy or complex regional pain syndrome.