

July 6, 2006

TX DEPT OF INS DIV OF WC
AUSTIN, TX 78744-1609

CLAIMANT:

POLICY: M5-06-1334-01

CLIENT TRACKING NUMBER: M5-06-1334-01/5278

Amended Review 07/18/06

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above mentioned case to MRIOA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA 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. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

Records Received:

RECORDS RECEIVED FROM THE STATE:

Notification of IRO assignment 6/5/06, 13 pages

EOB forms, 9 pages

RECORDS RECEIVED FROM THE REQUESTOR:

Letter from provider 6/9/06, 2 pages

Table of records sent, 1 page

Office notes Dr. Burdin: 4/29/04, 5/27, 6/11, 7/21/04, 8/10/04, 10/5/04, 10/26/04, 11/29/04, 12/29/04, 1/25/05, 3/29/05, 4/27/05, 5/27/05, 6/13/05, 6/29/05, 7/27/05, 8/29/05, 9/29/05, 10/24/05, 10/31/05, 12/2/05, 21 pages

Office notes M Dedmon PAc; 5/18/04, 6/8/04, 6/24/04, 7/15/04, 10/5/04, 11/30/04, 1/27/05, 2/10/05, 2/24/05, 3/10/05, 3/31/05, 5/10/05, 8/11/05, 8/16/05, 9/8/05, 9/29/05, 10/4/05, 10/12/05, 10/20/05, 11/22/05, 12/20/05, 1/24/06, 3/16/06, 4/20/06, 8/14/03, 9/9/03, 10/31/03, 1/2/4, 2/17/04, 58 pages

Office notes T Westfield MD; 6/3/04, 7/1/04, 7/8/04, 8/5/04, 10/6/04, 3/24/05, 2/9/06, 7 pages

Office notes M Freiberg MD; 6/8/04, 2 pages
EDX report 7/20/04, 19 pages
Work restriction note, B Burdin DC 1/13/05, 2 pages
Office notes D Hirsch DO; 4/6/05, 2 pages
Hand written notes; 5/2/05, 5/13/05, 3/6, 6/7, 6/13, 7/13–not signed, 6 pages
Neurology consult 5/3/05– M Lampert MD, 3 pages
Office notes M Lampert MD; 6/7/05, 7/14/05, 12/9/05, 1/13/06, 3/7/06, 4/18/06, 12 pages
Spinal range of motion and computerized muscle test 8/9/05
Letter from M lampert 2/16/06, 2 pages
Daily treatment log; 5/21/04–6/18/04, 8/17/05–12/9/05, 11/30/04–4/21/05, 107 pages
Various treatment log sheets, 4 pages
OT testing script 5/18/04 and prescriptions for treatment; 11/18/04, 2/10/05, 7/13/05, 7/27/05, 10/20/05, 11/22/05, 12/20/05, 2/16/05, 3/16/05, 10 pages
Office notes and work status reports; P Wilson MD; 6/29/04, 11/18/04, 12/16/04, 1/24/05, 3/8/05, 5/2/05, 9/12/05, 1/16/06, 4/10/06, 18 pages
Report MRI right shoulder 6/8/04, 1 page
Report x–ray right elbow 6/10/04, 1 page
Report x–ray thoracic and cervical spine 12/20/04, 2 pages
Report MRI cervical spine 2/11/05, 2 pages
Work status report D Burdin DC; 4/29/04, 5/27/04, 6/11/04, 7/21, 8/10, 10/5, 10/26, 11/29, 12/29, 1/25/05, 2/25, 3/29, 4/27, 5/27, 6/29, 7/22, 8/29, 9/29, 10/31,
Request to change treating doctor 1/3/06, 1 page
Work status report M Lampert MD; 1/13/06, 2/24, 3/7, 4/18, 5/16, 24 pages

RECORDS RECEIVED FROM THE RESPONDENT:

Letter from Gallagher Bassett 6/30/06, 2 pages
Review T Fahey DC 7/23/03, 3 pages
Review D Vo MD 10/13/03, 6 pages
Reviews M Albrecht MD; 10/17/05, 11/23/05, 5/23/06, 10 pages
Billing records; 12/20/05, 1/13/06, 2/9/06, 2/16/06, 3/7/06, 3/16/06, 4/18/06, 4/20/06, 5/16/06, 9 pages
EOB letters, 7 pages
Letter to insurer 3/14/06, 1 page
Prescription for cervical pillow 3/16/06, 1 page

Summary of Treatment/Case History:

The patient is a 42 year old female with a work related injury to the right arm on_____. The patient has continued to have pain in the right arm and upper trapezius. The patient is status post carpal tunnel and trigger finger releases. The patient treatment notes beginning April 2004 indicate the patient being treated with trigger point injections, therapy and medications. An MRI on 6/8/04 of the right shoulder demonstrated a small partial supraspinatus tendon tear. An EDX study on 7/20/04 was negative for radiculopathy and neuropathy. The patient had surgery on the right shoulder in mid Nov 2004 (Mumford procedure). This was followed by intensive therapy for the shoulder. Trigger point injections were done for the trapezius discomfort in May and June 2004. Additional injections were then done on 1/27/05, 2/10/05, 2/24/05, 3/10/05, 3/31/05, 5/10/05, 8/16/05, 9/8/05, 9/29/05, 10/20/05, 11/22/05, 12/20/05, 1/24/06, 3/16/06, and 4/20/06. A neurology consult on 5/3/05 did not note any localizing neuromuscular abnormalities. A request for ulnar nerve surgery at the elbow was apparently denied, as also was request for epidural steroid injections. The patient continued to demonstrate a myofascial pain pattern. Range of motion of the shoulder which initially had improved,

worsened and then remained essentially unchanged with minor variations. The patient continued with therapies and treatment by the various providers at the institute. Ongoing care documentation included is through April 2006 without significant change in any of the problems.

Questions for Review:

DOS 3/29/05 through 9/29/05:

1. Please review for medical necessity of disputed services.

Services Disputed: Office visits (#99212, #99212-25, #99213, #99213-25, #99214), Manual Therapy technique (#97140-59), Therapeutic exercises (#97110-GP) special reports (#99080-73), Non-emergency transportation -wheelchair van (#A0130), exercise equipment (#A9300), muscle testing-extremity (#95831), electrical stimulation (#G0283, #G0283-GP), ultrasound (#97035-GP), WHO Wrist extension control cock-up (#L3908), electrodes (#A4556), DME-Misc (#E1399), Injection single or multiple trigger points 3 or more muscles (#20553), Syringe with needle sterile 5 cc or greater (#A4209) an injection Bupivacaine HCl 30 ml (#S0020).

Explanation of Findings:

This patient has multiple ongoing problems and care appears to be addressed to the various problems by the different providers.

a) CTS and hand injury: This appears to be the significant initial injury resulting in surgical releases. The ongoing complaints related to the hand and wrist appears to be that of pain and numbness and occasional triggering. AS this review is regards to treatment beginning 3/29/05, the issue of initial development of the CTS and trigger fingers will not be addressed. The ongoing notes continue to state that the patient has ongoing CTS. However, this is not demonstrated objectively in the documentation. The EDX study of 7/20/04 was normal with no evidence of CTS. The various exams throughout only note a positive Tinel which is a 'soft' sign only and not diagnostic of CTS. It may in fact be due to the prior surgery or local injection which may have irritated or injured the nerve and caused a neuroma to develop or to sensitivity at the surgical scar site. The clinical diagnosis would be based on appropriate sensory or motor abnormalities and nerve conduction study abnormalities. This has not been demonstrated. The initial consult from Dr. Lampert on 5/3/05 noted that the "sensory deficit is histrionic in nature". No localizing sensory deficits noted. There was no weakness noted. Also "histrionic motor responses are noted". Given this report, the absence of exams noting a CTS sensory loss, and the normal EDX study, no diagnosis of ongoing CTS can be made and no rationale for any further testing or treatment for this issue. In summary, medical necessity is not established for any care, testing or treatment during the dates in review for carpal tunnel syndrome or any other hand problem.

b) Cubital tunnel syndrome: There is frequent mention of cubital tunnel syndrome or ulnar nerve entrapment at the elbow. However, the EDX study of 7/20/04 was negative and did not demonstrate this. The neurology consult of 5/3/05 only noted hypalgesia of the entire right arm and leg. There were no localizing findings of ulnar sensory nerve compromise. Strength was intact as no weakness in any group was noted and also no indication of any ulnar nerve innervated atrophy. This would also argue against a significant ulnar nerve problem. In the next note he indicated suggestion of C6 changes with still diffuse non radicular hypalgesia. By January 2006 he was noting moderate hand intrinsic weakness. This would indicate that if there was such a problem, it did not develop initially the last half of 2005. The diagnosis of ulnar nerve entrapment is not clear, as the problem may just as well be lower cervical radiculopathy. EDX studies would be appropriate to make the diagnosis. However, in any case, medical necessity has not been established for any of the therapy, injections or care provided for this problem during the period in review.

c) Rotator cuff injury: While it is not clear why a Mumford procedure was done given the minimal supraspinatus tear on MRI and normal AC study, the patient did have surgery and needed therapy after the surgery for the shoulder. The patient did in fact improve initially. By 12/29/04 the patient had passive flexion of 160 degrees, almost full internal rotation and 65 degrees external rotation. On 1/25/05 the pain level from the shoulder was reduced to 2/10. by 1/27 the abduction had decreased to 100–110 degrees. On 3/29/05 range was 90 active and up to 135 passive which is essentially where it has remained. Given the lack of progress after 3 months of therapy, no medical rationale to continue with the same program. The patient required orthopedic reevaluation at that point in time. Treatment by the end of March far exceeded Milliman Care guidelines. The patient should have been on an active home exercise program as well. Therefore, medical necessity has not been established for continuation of the therapy post shoulder surgery during the dates of service in review.

d) Myofascial pain syndrome: The notes all indicate a diagnosis of myofascial pain syndrome with chronic pain in the trapezius, rhomboid etc. This problem was noted to be ongoing in the note from M Dedmon of 2/17/04. The review of Dr. Albrecht of 10/17/05 notes neck complaints in Nov 2002. These notes indicate chronic cervical myofascial pain. A significant portion of the treatment was also directed to this problem but without any significant documented objective improvement. There is no literature support for the use of passive modalities such as manual therapy, electrical stimulation, ultrasound, etc for this problem. The literature does not indicate therapy being efficacious in management of such chronic pain problems and instead indicates that multidisciplinary behavioral and functional oriented pain management programs should be utilized. There is no literature support for repeat trigger point injections either. As noted above the patient had frequent and numerous sets of injections. This treatment is not supported in patients with long standing and chronic myofascial pain. Therefore, medical necessity has not been established for any of the therapies or injections (#20553, #A4209, #S0020) for this problem during the dates of service in review.

e) Cervical radiculopathy: There is no real data supporting this diagnosis. The EMG was negative. The neurology consult of 5/3/05 noted no motor or reflex deficits and the sensory findings were noted to be "histrionic". The motor responses were also noted to be histrionic. The MRI demonstrated minor disc changes without any central or root level entrapment or stenosis. Only on a subsequent exam was it noted that there may be subtle C6 sensory changes although no other C6 changes were noted. Given the lack of supporting information this diagnosis cannot be supported. The patient had prolonged therapy for neck pain prior to March 2005 without significant objective sustained improvement. Therefore, medical necessity has not been established for any of the testing and care for this problem.

f) E/M visits (#99212, #99213 and #99214): Given the prolonged treatment prior to 3/29/05 without any significant improvement and no significant modification of the treatment approach and program, medical necessity has not been established for any of the care including office visits during the period in review.

g) Supplies (#L3908, #A4556, #E1399, #A9300): There is no medical necessity for a wrist cock up splint. No radial weakness documented. No specific diagnosis of CTS established as noted above. No indication or necessity for electrodes as no documentation of the patient using a TENS unit at home regularly. No documented necessity for home exercise equipment and no indication of the patient being instructed and utilizing equipment in a home program.

h) Misc: (#99080, #A0130, #95831), No documented need for special reports and no request from the carrier for a written report. No documented need for a wheelchair van as no documented lower

extremity problem. There is no medical necessity for range of motion and muscle testing, as there is no literature evidence that these studies provide any significant additional information as compared to the clinical evaluation in such patients.

Conclusion/Decision to Not Certify:

In summary, care prior to 3/29/05 has been prolonged without significant objective sustained improvement. Medical necessity has not been established for any of the therapy (#97140, #97110, #G0283, and #97035) or any of the other services provided (#99212, #99213 and #99214, (#20553, #A4209, #S0020, #L3908, #A4556, #E1399, #A9300, #99080, #A0130 and #95831) during the period in review (3/29/05 – 9/29/05).

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

Clinical review

Milliman Care guidelines 10th edition, ambulatory

Medline search

References Used in Support of Decision:

Practice parameters for EDX studies in CTS: summary statement. Muscle and Nerve June 2002, 25, 918–922

A review of treatment for CTS: Disabil Rehabil Feb 4, 2003, 25(3), 113–119

Interventions for shoulder pain. Cochrane database system rev 2000(2) CDOO1156

A randomized clinical trial evaluating the efficacy of physiotherapy after rotator cuff repair. Aust J Physiothe 2004, 50(2), 77–83

Self training vs physiotherapist supervised rehabilitation of the shoulder in patients treated with arthroscopic subacromial decompression: A clinical randomized study. J Shoulder, Elbow Surg March–April 1999, 8(2), 99–101

Clinical practice guidelines for chronic non–malignant pain syndrome patients II: An evidence–based approach. J Back Musculoskeletal Rehabil. 1999;13:47–58.

Trigger point injections for chronic non–malignant musculoskeletal pain. Health Technology Assessment 35. Edmonton, AB: Alberta Heritage Foundation for Medical Research; January 2005. <http://www.ahfmr.ab.ca/publications.html>.

Multidisciplinary group programs to treat fibromyalgia patients. Rheum Dis Clin North Am. 1996;22(2):351–367

Multidisciplinary biopsychosocial rehabilitation for neck and shoulder pain among working age adults. Cochrane Database Syst Rev. 2001;(3):CD002194.

Electrical stimulation. CIM Manual section 35–46

This reviewer is Board certified in Physical Medicine & Rehabilitation (1979). The physician providing this review is a Diplomate, American Academy of Physical Medicine and Rehabilitation; and Diplomate, American Board of Electrodiagnostic Medicine. This reviewer is a member of the American Spinal Injury Association, American Academy of Physical Medicine and Rehabilitation, State Academy of Physical Medicine and Rehabilitation, and State Medical Society. This reviewer has held various academic positions, is currently an Adjunct Associate Professor, and has authored numerous publications. The reviewer has additional training in Acupuncture. This reviewer is licensed to practice in four states and has been in practice since 1978.

MRloA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the DWC.

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Case Analyst: Stacie S ext 577

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