

July 3, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0592-01
IRO Certificate No.: IRO 5055

Dear

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). Texas Workers' Compensation Commission Rule 133.308 "Medical Dispute Resolution by an Independent Review Organization", effective January 1, 2002, allows an injured employee, a health care provider and an insurance carrier to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating physician. Your case was reviewed by a physician reviewer who is Board Certified in Physical Medicine and Rehabilitation and Electrodiagnostic Medicine.

THE PHYSICIAN REVIEWER OF THIS CASE AGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE. The reviewer states no evidence exists to substantiate that injections to the cervical spine would benefit this condition.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) 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
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

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.

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 November 26, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for _____. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0592-01, in the area of Physical Medicine and Rehabilitation. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Disputed services: Cervical facet injection at multiple levels with six sessions of post-injection physical therapy.
2. Medical records of Utilization reviewers.

3. Physical Medicine peer review on April 11, 2002, from ____.
4. Letters of medical necessity from ____.
5. ____ office notes.
6. Operative reports.
7. Impairment rating done by ____ done on March 28, 2000, with of 24% rating.
8. Review by ____.
9. Review by ____.
10. Two electrodiagnostic studies.
11. The first report from when the patient was seen by ____.
12. Various physical therapy notes.
13. Report of the sacroiliac joint injections.

What is missing, however, and I have tried to get this with the help of the company who has hired me, are any x-ray studies or MRI's, any imaging studies whatsoever of the neck, because this is the item that is in dispute. I believe it is essential to get these studies because, from the book by Kaneer on pain management, i.e., the role of facet blockade, it is generally done for hypertrophic arthropathies, osteophytic degeneration, arthritic changes which are postulated to cause this kind of pain. Thus, anesthetic blockade of the medial branch helps to make this diagnosis. Eventually, one considers cryo or radiofrequency neurolysis of the medial branch. There needs to be some justification along these lines to do a facet blockade.

B. BRIEF CLINICAL HISTORY:

There are various histories in the chart. However, I will go with ____ history, which was the first visit by him. This is dated May 28, 1998, at which time it was noted that the patient had an injury on ____ when a steel beam fell and hit him, pulling his right upper extremity. He suffered a laceration to the right ring finger and pain to the right shoulder.

There is an MRI of the right shoulder noted.

The examination is somewhat difficult to interpret. It states that he has paracervical muscle tenderness with spasms in the right trapezius. The examination of the spine is normal, with a normal range of motion, nontender, no masses. The assessment is cervical strain, however. The neurologic exam is apparently normal, though in a different place it says there is decreased sensation over the small finger, that there is a right ring finger scar, which is a little bit confusing.

Surgery is recommended at that time, and eventually was performed.

There are two electrodiagnostic studies, and I will comment on them because this is part of the clinical history. One was done on October 1, 2001, by _____. The signatory of this is _____, a physical therapist. It is read as a normal study. However, in looking at the raw data, I do not believe this is a normal study. For example, the motor nerve studies show that the median nerve has a motor latency at the wrist of 4.5 msec on the left and 5.3 msec on the right; these are clearly abnormal. When one compares them with the ulnar nerve, the values are 3.4 msec and 3.3 msec, grossly abnormal. The sensory latencies, however, are normal.

There is another problem; for example, the ulnar motor nerve conduction across the axilla is given as 46 meters/second, whereas all the other velocities are in the 60's. This clearly implies a tardy palsy of some sort, or else damage in the axillary area, i.e., a brachial plexus injury. I believe this is very important to consider because, in a later study, done by _____ on March 4, 1998, again there are the same discrepancies, i.e., the right median motor velocity is 39 meters/second. There is a left ulnar motor velocity of 83 meters/second, and the other velocities are in the 30's for the median sensory, ulnar sensory, and radial sensory. There is a tremendous discrepancy in these. Again, his report is that there is abnormal upper extremity nerve conduction velocity due to slight prolongation of the sensory distal latencies of the left ulnar and right radial nerves. This is clearly not the case when looking at his data. He concluded that there is a C-6 radiculopathy. There is no evidence for this.

My point is that these two electrodiagnostic studies clearly indicate pathology in the right arm, not in the cervical spine. An EMG is also done, and it too does not confirm any type of radiculopathy.

Again, the point is that these two electrodiagnostic studies point to pathology unexplained by either examiner and indicate pathology from the shoulder distally, not a cervical spine problem. There is no case for a C-6 radiculopathy whatsoever, nor for any other cervical radiculopathy.

The MRI of the right shoulder does not comment on any abnormalities in the brachial plexus.

One of the basic problems in this case is that from a shoulder/arm/finger injury, somehow a back injury, i.e., chronic low back pain, is postulated on December 12, 2001. Sacroiliac joint injections have been performed. The neck is postulated far after the shoulder injury as being a cervical strain. I believe the electrodiagnostic testing by the two examiners probably was misleading to _____.

Then, of course, the charts clearly state that there is bilateral groin pain and bilateral leg and knee problems, and that the patient is walking with a device because of pain in the leg including the knee.

The postulate is that the patient injured himself while doing functional capacity evaluation.

C. DISPUTED SERVICES:

The disputed services are the facet injections.

D. DECISION:

I AGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:

This gentleman had a documented injury to the shoulder with a traction injury. I believe that the neurological findings, although scant but real, are related probably to a plexitis, i.e., a brachial plexus injury. At least, that was the case back in 1998 and also in 2001 when the second examiner did electrodiagnostic studies.

I do not believe that there is any evidence for a cervical spine injury. It is reasonable when one has an injury to the shoulder to postulate a cervical injury, i.e., when there is pain in the shoulder, it could clearly be radicular. However, the only time the neck is indicated is that there is some trapezius spasm. Spasm is a term generally applied to protective contraction, i.e., when there is pain, muscles contract and it is felt as a hard muscle. This is sometimes called a spasm. A spasm is not a disease; it is a reaction to pain.

Thus, again, there are no physical findings, no electrodiagnostic findings, and no x-ray evidence that there is any cervical pathology.

I have not been asked to comment on the treatment other than the shoulder, i.e., the back, the hip, the knee, the sacroiliac joint. Since I do not believe that any of these are related to the original injury, I will ignore them for the rest of this narrative.

Based on the medical records submitted, there is absolutely no evidence that injections to the cervical spine would benefit an injury-related condition. It may well be that this gentleman has degenerative joint disease in multiple joints, i.e., the hips, the knees, and the neck, but there is no evidence that there is any connection of the neck problem with the

injury. There simply is not a direct trail of the cervical injury, nor to the back, nor to the hip or groin.

Thus, based on the lack of evidence for pathology in the cervical spine, it is my opinion that any treatment rendered to the cervical spine, to include the facet injections, which usually is ultimately a neurolysis, is unwarranted as part of the injury. There may well be facet hypertrophy, but it has to be shown that this developed as a consequence of this injury which is somewhat unlikely. It is more likely that with the neck, back, groin, and knee pain, this gentleman has degenerative joint disease, all not part of the injury of ____ .

It also appears that he has now developed a carpal tunnel, i.e., compression neuropathy at the wrist.

He is also being treated for headaches, considered to be occipital neuralgia. Again, this has no bearing on the facet injection problem nor on the compensable injury.

In conclusion then for an injury of ____, involving the right shoulder with an extensive amount of surgery, I believe this gentleman has no documentable evidence that the cervical spine was injured, such that it requires facet injections as part of the injury.

I would be happy to see the x-rays of the cervical spine from 1998 or even shortly thereafter, but findings 4½ years after an injury are inconceivably part of the original injury. This patient was seen by many physicians and it is hard to assume that cervical spine injuries were not noted for 4½ years while he was having extensive amounts of treatment on his shoulder, extensive amounts of physical therapy, electrodiagnostic testing on two occasions, and MRI's of his shoulder, follow-up x-rays of his shoulder, and work on his shoulder and hand.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 2 July 2002