



Specialty Independent Review Organization, Inc.

June 14, 2005

TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M2-05-1708-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO 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.

This case was reviewed by a licensed Medical Doctor with a specialty in Neurology. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The records indicate that Ms. ___ has been employed by a supermarket.

According to an initial injury report obtained by Dr. Richard Chengson, on July 28, 2004, Ms. ___ suffered an on the job injury. Apparently she fell backwards at work after a fellow coworker came up suddenly and bumped into her. She struck her right elbow on a cabinet as she was falling on to her left side.

She was seen by Dr. Chengson on the day of the injury and was unable to straighten the right elbow secondary to pain, particularly over the medical aspect. She had had no prior history of

right elbow injuries. Dr. Chengson's initial examination showed that she held the right elbow in a protected position at 90 degrees flexion and was acutely tender over the olecranon process and the medial epicondyle of the distal humerus. She had limited range of motion due to significant pain overlying the elbow joint, especially over the medial aspect. There was no evidence of ecchymosis or skin lesion. She had good grip strength in the right hand and no obvious injury to the wrist, forearm, or fingers of the right hand. X-rays were negative. The initial impression was contusion of the right elbow and he recommended Lortab, plus continuation of Vioxx, plus ice, and work restrictions.

Ms. ___ was seen subsequently by Dr. Rowena Archibald, who is in the same practice as Dr. Chengson. She was re-evaluated on August 05, 2004 and she felt she was 75 percent back to normal, but was extremely sore medically over the distal upper arm. She denied any swelling, sweating, temperature changes, or other symptoms consistent with reflex sympathetic dystrophy. On the examination, she was exquisitely tender over the medial aspect of the elbow approximately 2 cm proximal and 2 cm distal to the medial epicondyle. Sensory testing and strength testing of the hands was normal. There were no clinical signs of RSD. She was unable to fully extend the elbow. She was evaluated by a physical therapist at that visit, and was told her continue ice and Vioxx.

On August 11, 2004 she reported to Dr. Archibald that she was having some paresthesias in her right ring and small fingers. She was making some progress with physical therapy, but had discomfort with any type of maneuvers that put stress on the elbow. She had decreased flexion due to discomfort and she was extremely tender around the right medial epicondyle. She was told to discontinue physical therapy, as it did not seem that this was helpful. On August 18, 2004, she was reported to have been working outside her restrictions lifting up to 200 pounds of cookie dough. Dr. Archibald discussed with Ms. ___'s supervisor, Mr. Collins, that she needed to be kept on her restrictions to help hasten her recovery. Subsequent visits indicate that on September 20, 2004, an attempt was made to perform an MRI of the right elbow, but she could not tolerate it. Nerve conduction studies were also done, which had shown some abnormalities of her ulnar nerve. She had also seen an anesthesiologist who attempted a stellate ganglion block, unsuccessfully. After this attempted block, she reported that her right hand was sweating excessively. She continued to have paresthesias in her ring and small fingers. Dr. Archibald was not convinced that she had RSD, but thought she may have had some irritation of the sympathetic fibers of the ulnar nerve.

On September 08, 2004, Ms. ___ reported to Dr. Archibald that she did in retrospect notice some vague differences between the two hands with regard to temperature, sweating, and swelling for the last 2-3 weeks. She was trying another anti-seizure medicine for pain. She was seeing Dr. Oliva for repeated stellate ganglion blocks. She thought she was slowly improving. On examination, her right hand did feel slightly cooler and more moist than the left and appeared to be faintly more red than the left. On September 27, 2004, Dr. Archibald noted that Ms. ___ had a successful stellate ganglion block on September 24, 2004, but was still having pain. Her pain had decreased to a level 6 out of 10. She was still having aching and burning pain and sharp pain

near the elbow. Examination showed reduced strength to right digit abduction and adduction. On October 04, 2004, Dr. Archibald noted that an MRI of the elbow was normal. Repeat nerve conduction studies performed on September 15, 2004, revealed right cubital tunnel syndrome.

In subsequent notes with Dr. Archibald, Ms. ___ was noted to continue to have symptoms of right forearm and elbow pain. On November 10, 2004, they discussed an attempted surgery by Dr. Garcia, a hand surgeon. They were not able to achieve successful anesthesia of the right elbow, which made the various providers think that she could have essentially mediation pain process i.e. sympathetic dystrophy. The patient was becoming excessively upset and agitated regarding her chronic pain. Dr. Archibald suggested possible counseling.

On November 24, 2004 Dr. Archibald added Zoloft. When she returned on December 02, 2004 Ms. ___ reported she was feeling much better. She had had some additional blocks done by Dr. Oliva the anesthesiologist. She was still having some burning and numbness. Her examination was unchanged. On March 02, 2005 they discussed the fact that Dr. Oliva was trying to get authorization to do cervical epidurals. On March 16, 2005 she was described as remaining hyperpathic around her medial epicondyle. On April 13, 2005 she was experiencing intermittent shaking episodes lasting about an hour, happening once or twice day. These seemed to be related to effort. They were usually preceded by a sharp pain in the elbow. She complained that her hands were "freezing off". She denied any change in her paresthesias or strength. Her examination was unchanged with extreme tenderness over the right elbow. Dr. Archibald recommended a neurology evaluation. She also felt that while the disability carrier had felt that she had reached maximum medical improvement and could return to work, in Dr. Archibald's opinion, she had not reached maximal medical improvement and could not return to unrestricted activities. There were no further notes submitted from Dr. Archibald.

The records from Dr. Michael Oliva, a pain management specialist, indicate an initial assessment on September 07, 2004 with an impression of a complex regional pain syndrome type 1 involving the right upper extremity. He recommended stellate ganglion blocks. These were performed on September 16, 24, and October 07, 29, and November 01, 05 2004. Another office visit was performed on January 19, 2005. At that time, he recommended a radio frequency procedure of the stellate ganglion in the right side. This was performed on February 14, 2005. On a follow-up visit on March 02, 2005, Dr. Oliva noted that an MRI of the cervical spine show evidence of a fusion at C5-6, with some degenerative disk changes at C4-5 and C6-7 and that it was possible some of her symptoms could be due to her disk pathology. Therefore, he recommended cervical epidural steroid injection at C6-7 on the right.

Records are submitted from Dr. Melinda Garcia, a hand and upper extremity specialist. She first evaluated Ms. ___ on September 01, 2004. Her examination showed tenderness to palpation along the course of the ulnar nerve and the distal half of the forearm with mild soreness elicited on palpation of the triceps. She did not examine the neck. Her impression was on the job direct trauma to the right medial elbow now with ulnar nerve neuritis and concern for component of sympathetically mediated pain. She recommended an EMG/NCV and MRI plus treatment with Vioxx and Keppra and referral to Dr. Oliva. She was seen again on October 05, 2004. Again,

recommendation was made for 2 or 3 additional stellate ganglion blocks. At a return visit on January 19, 2005 they discussed the fact that they were unable to fully anesthetize the right elbow during attempted ulnar nerve transposition suggestive of essentially mediated pain syndrome. Dr. Garcia wrote that here was "no evidence of C-spine pathology".

Nerve conduction studies were performed on Mr. ___ on September 15, 2004. This showed ulnar nerve swelling at the elbows bilaterally, actually worse on the left side than the symptomatic right side. However, there was an asymmetry of sensory amplitudes with the right being significantly decreased compared to the left. A needle study was not performed. The right F-wave latency was slightly prolonged compared to the left. There was no definite evidence of conduction block on the right side. A second set of nerve conduction studies was performed on January 10, 2005. This as performed by the same physician and revealed improved conduction velocity across the right elbow with no decrease in motor amplitudes. The right ulnar sensory amplitude improved. Again, needle EMG examination was not performed. The right ulnar nerve F-wave latency was obtained, but the left ulnar nerve F-wave latency was not performed, so a comparison could not be made.

Ms. ___ underwent a required medical examination by Brian C. Buck, MD on May 04, 2005. Dr. Buck noted that she could take on and off her jacket without difficulty. She did guard her right elbow. She had allodynia along the right medial elbow. She had right elbow flexion to 128 degrees and lacks 32 degrees of full extension. He found no evidence of epicondylitis or triceps tendonitis. At the wrist, she had a positive Tinel's and negative carpal-tunnel compression test. There was no intrinsic atrophy of the hands. She had symmetrical forearm circumferences and symmetrical fine hair on the dorsal radial forearms. Strength was symmetric. Sensory testing was symmetric. She did report numbness in her right 4th and 5th fingers and had some bilateral finger clubbing. Dr. Buck felt she had right ulnar neuritis without classic RSD and she may have complex regional pain-syndrome type 2. He found no evidence of aggravation of a pre-existing degenerative disease in her cervical spine. He felt there was no relationship between her injury, the complex regional pain syndrome, and her cervical spine.

Other pertinent test results submitted included an MRI of the right elbow and proximal right forearm obtained on October 01, 2004. This was normal. Plane spine x-rays obtained on November 11, 2004 showed evidence of a congenital fusion involving the vertebral bodies of C5-6 with moderate to severe loss of disk height with bulky endplate spring at C6-7 and severe facet arthroses bilaterally at C6-7 and C7-T1 and "mild dynamic slippage" at the C3-4, and C4-5 levels. An MRI of the cervical spine with and without contrast on November 19, 2004 showed an osseous fusion of the bodies of C5-6. There was no spinal stenosis. At C3-4, there was mild bulging of the disk annulus without herniation or spinal stenosis. At C4-5, there was desiccation with mild disk mild disk space narrowing, but no complete loss of disk volume. Central bulging of the annulus was present without herniation or stenosis. The exit foramina were patent. No stenosis was seen at the fused C5-6 level. At C6-7, there was desiccation with disk space narrowing and broad disk space bulging, but no herniation or stenosis. The exit foramina are patent. The C7-T1 level was normal.

Records Reviewed:

1. Office progress notes and TWC work status reports, Richard Chengson, MD and Rowena Archibald, MD, July 28, 2004 through April 16, 2005.
2. Pain management consultation, procedure notes, and office progress reports, Michael Oliva, MD, September 07, 2004 to March 2, 2005.
3. Hand surgery consultation and office progress notes, Melinda Garcia, MD, September 01, 2004 to January 19, 2005.
4. Physical therapy progress notes, Physical Therapy Associates, August 05, 2004.
5. Neurophysiology consultation, Bhupesh Dihenia, MD, September 15, 2004 and January 10, 2005.
6. MRI of the right elbow October 01, 2004.
7. Cervical spine with oblique flexion and extension, November 11, 2004.
8. MRI of the cervical spine with and without Gadolinium, November 19, 2004.
9. Required medical examination, Brian C. Buck, MD, May 4, 2005.
10. Letter to Michael Oliva, MD from Diane Kamler from Concentra , March 9, 2005.
11. Letter to Michael Oliva, MD from Theresa Bechtolt from Concentra.
12. Correspondence to Siro from Debra Womack, Attorney at Law, dated Wednesday May 25, 2005.

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of a cervical ESI at C6-7.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

There is no clinical evidence to indicate that Ms. ___'s symptoms may be due to cervical spine pathology. She has had no history of neck pain or radicular type symptoms. Her injury on ___ was to her right elbow. Throughout the detailed notes of Drs. Chengson, Archibald, Oliva, and Garcia, her complaints have focused on elbow pain and forearm and hand symptoms without any mention made of neck or shoulder or proximal upper extremity complaints. The report of the MRI does not suggest any encroachment or narrowing of her neuroforamen. She has no clinical findings to suggest cervical radiculopathy such pain radiating down the extremity, weakness, numbness or reflex abnormalities in an appropriate dermatomal or myotomal distribution.

References:

International Research Foundation for RSD/CRPS. Reflex sympathetic dystrophy/complex regional pain syndrome. 3rd ed. Tampa (FL): international Research Foundation for RSD/CPRS; 2003 Jan 1.

Manchikanti L, PS Staats, V Singh, et al. Evidence-based practice guidelines for interventional techniques in the management of chronic spinal pain. *Pain Phy* 2003; 6:3-81.

Washington State Department of Labor and Industries: Complex regional pain syndrome (CPRS) Olympia (WA) Washington State Department of Labor And Industries; 1999 Jun.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) 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 Worker's Compensation Commission, P.O. Box 17787, Austin, TX 78744. The fax number is 512-804-4011. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(u)(2).

Sincerely,

Wendy Perelli, CEO

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 17th day of June 2005

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli