

# IRO America Inc.

## An Independent Review Organization

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Corrected July 17, 2006

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TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: \_\_\_\_\_

TDI-DWC #: \_\_\_\_\_

MDR Tracking #: M2-06-0602-01

IRO #: 5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America 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.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed MD, board certified and specialized in Orthopedic Surgery. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

### **RECORDS REVIEWED**

Notification of IRO Assignment, records from the Requestor, Respondent, and Treating Doctor(s), including:

- Consultation with Dr. Schaffer 04/26/93
- CT of brain 05/04/03
- Lumbar and cervical spine MRI, 05/05/93
- Office note of Dr. Theilen 05/19/93
- Office notes, Dr. Michaelson, 02/14/94, 03/25/94, 09/08/98 and 04/02/03
- Bone scan 02/21/94

- Electroencephalogram, 02/24/94
- Office note of Dr. Elbaor 08/02/96, 09/17/97
- Right upper quadrant sonogram 02/27/97
- Functional capacity evaluation, 09/17/97
- Notes, 01/08/98, 01/13/98
- Office note, Dr.Mohammed 02/18/99
- Discharge summary, 02/20/99
- Review, Dr. Gragnani, 10/10/00
- Independent review decision, 06/08/02
- Office note, Dr. Callewart 06/13/02
- Office note, Dr. Erwin 07/10/02
- MRI of the brain, 05/05/93
- Medical necessity for attendant, 01/26/04, 11/21/05 and 12/05/05
- Note, Dr. Bierner 04/14/04
- Office note, Dr. Yabraian, 10/17/05, 10/26/05, 12/02/05, 12/19/05 and 02/03/06

### **CLINICAL HISTORY**

The Patient is 38 years of age. He fell at least 10 feet and had an episode of loss of consciousness. Dr. Schaeffer evaluated The Patient on 04/26/93 for a myriad of symptoms relative to his neck, memory, vision, low back and lower extremities. He was diagnosed with a concussion, possible post-concussive syndrome, left greater occipital neuralgia, right brachial plexus injury, rule out other peripheral nerve injury, rule out myelopathy, traumatic lesion of the spine, or herniated disc. Dr. Schaeffer recommended neuropsychological testing, an MRI of the head, cervical, thoracic and lumbar spines, a bone scan and possible blocks.

A CT of the brain performed on 05/04/93 showed chronic ethmoidal sinusitis. A 05/05/93 MRI of the lumbar spine demonstrated mild to moderate disc space narrowing at L4-5 with mild to moderate decreased signal within the disc consistent with disc degeneration or desiccation, a small disc herniation at L4-5 paramedian on the right with annular bulging also present posteriorly of a mild degree, and a mild disc space narrowing and mild to moderate degenerative disc signal at L5-S1 consistent with degenerative disc changes with mild diffuse annular bulging with suggestion of slight spondylolisthesis at L5-S1. An MRI of the cervical spine was normal. On 05/19/03 The Patient was diagnosed with vertigo, tinnitus, possibly from inner ear dysfunction or trauma. A bone scan of 02/21/94 and an electroencephalogram of 02/24/94 was normal. The Patient underwent an L4-5 and L5-S1 fusion in 08/94 and a right knee arthroscopy in 02/95. He was declared statutory maximum medical improvement as of 04/15/95.

Dr.Gragnani evaluated The Patient on 10/10/00 stating that it was unusual to have reflex sympathetic dystrophy of all four extremities. He did not feel a 24 hour attendant, aquatic therapy, ganglion blocks, or surgery were necessary and recommended a psychological evaluation.

The Patient continued treating for diagnoses of internal derangement of the bilateral knees chondromalacia versus meniscal tear, cervical spine syndrome, possible radicular right C7, possible tardy ulnar palsy right elbow, right wrist trauma, possible navicular lunate trauma, rule out bilateral carpal tunnel syndrome, right shoulder impingement versus glenoid labrum tear or partial rotator cuff tear and seizure disorder through 06/02. A review of 06/08/02 agreed that an attendant was not necessary.

On 06/13/02 Dr. Callewart evaluated The Patient stating that as of 4/21/98 he estimated permanent disability of 11 percent. He did not see a neurological deficit and suspected he was mobile at home, despite his use of a wheelchair.

The office note of 07/10/02 noted The Patient's multiple body complaints and his claim that he needed assistance for a lot of activities, but could dress himself except for his pants and tying shoes. He was in a wheelchair as he claimed he could not use his legs. He walked with a cane, but was unsteady. The examination noted that he took quite a while to get out of the chair and once standing waited several minutes before he was able to pick up the cane. He shook and trembled as he attempted to walk and had tremulousness in all extremities with shaking of all extremities in an unorganized fashion. On examination of the neck and upper extremities there was diffuse tenderness to palpation of the paracervical musculature, however, this was only with deep palpation. He reported pain with extension and full flexion. Examination of the shoulder noted the inability to abduct or flex the arms above 90 degrees and claimed he had bilateral bursitis due to reflex sympathetic dystrophy. He was unable to reach opposite shoulder with right or left hand and unable to reach the back of his head with the hands. The back evaluation noted The Patient's inability to walk on his toes or heels and could barely move across the room using a cane. He had diffuse tenderness to palpation of the paralumbar muscle, however, only with deep palpation. There was marked limitation in range of motion of the back, but in a seated position he could forward flex to approximately 35 degrees, extend 10 degrees, and bilaterally laterally flex 20 degrees. Straight leg raise in the seated was 90 degrees bilaterally without complaints of back pain. He continually shook his legs in tremors as he tried to do straight leg raise in supine and could lift his legs actively off the table about 20 to 30 bilaterally, but shook uncontrollably and claimed this causes pain and had no significant strength. Waddell testing was positive. There was a stocking glove type pattern of decreased sensation in a non-dermatomal distribution. Lower extremity exam noted that the strength was invalid due to give way. Dr. Erwin diagnosed The Patient with a somatoform disorder versus factitious disorder. Dr. Erwin did not feel he had RSD and stated there was pre-existing psychopathology.

Dr. Michaelson performed an RME on 04/02/03 and performed a record review at which time it was noted that an MRI of the right knee on 12/07/96 showed grade II intrameniscal signal involving the posterior horns of the medial and lateral menisci, some fraying of the free edge of the lateral meniscus, and a small amount of fluid in the deep infrapatellar bursa. An MRI of the lumbar spine performed on 06/06/97 was noted to show a status post lateral interbody fusion of L4-5 which appeared solid. There was a question of residual right lateral recess protrusion at L4-5, possibly compressing the traverse right L5 nerve root. He indicated that an MRI of the right shoulder on 01/28/99 showed mild subacromial-subdeltoid bursitis and mild tendinopathy of the supraspinatus tendon without evidence of a tear. An MRI of the left shoulder showed mild subacromial-subdeltoid bursitis and degenerative change of the posterior glenoid labrum without evidence of a tear. At the time of the 04/02/03 visit he reported continued difficulties relative to his neck, back, shoulders, headaches, dizziness and blackouts. The Patient reported the inability to ambulate, drive, dress himself, put on his underwear or cook. He needed assistance with bathing and could not remember to take his medications, but could feed himself. Dr. Michaelson indicated that due to his multiple medical problems, he agreed with Dr. Sarris who recommended attendant care 24 hours a day, seven days a week.

On 01/26/04 the use of an attendant 24 hours a day 7 days a week was approved. However, it was to be scrutinized every 90 days. On 04/14/04 Dr. Bierner stated that the mother was not qualified to render care and denied attendant care even if there was suicidal tendencies and a panic disorder. On 11/21/05 and 12/05/05 the need for an attendant was denied.

Dr. Yabraian evaluated The Patient on 10/17/05, 10/26/05, 12/02/05 and 12/19/05 for continued bilateral shoulder, lumbar spine and right knee symptomatology and diagnoses of upper and lower extremity complex regional pain syndrome and underlying psychological factors. He recommended that his mother continue to be his caregiver from 06/25/05 through 06/25/06. Cervical sympathetic blocks without steroids were recommended.

The most recent office visit is dated 02/03/06 by Dr. Yabraian at which time The Patient reported suffering a blackout and head concussion with loss of short term memory on 02/01/06 as a result of the injury on \_\_\_\_\_. The Patient was noted to have received bilateral cervical sympathetic blocks in the bilateral upper extremities with significant improvement. He complained of similar symptoms of redness, swelling and increased perspiration in both lower extremities and requested a lumbar sympathetic block. The examination noted decreased redness, swelling and minimal perspiration in both upper extremities, the ability to fully flex and extend the bilateral hands and fingers. Examination of the lower extremities showed slight hyperhidrosis from the hips on down and moderate swelling in both lower legs. There was slight discoloration and mottling from the knee down to both feet. An MRI of the brain and bilateral lumbar sympathetic blocks of both lower extremities were recommended.

### **DISPUTED SERVICE(S)**

Under dispute is the prospective, and/or concurrent medical necessity of: Attendant care 24/7 11/21/05 thru 06/25/06.

### **DETERMINATION/DECISION**

The Reviewer agrees with the determination of the insurance company.

### **RATIONALE/BASIS FOR THE DECISION**

The request was for attendant care 24/7 from 11/21/05 through 06/25/06. Based on the record review, this gentleman has extensive subjective complaints with no definitive diagnosis. The Reviewer could see no medical rationale why this individual would require attendant care 24/7. Records do not contain any objective evidence of anatomical weakness, loss of sensation or other significant neurological pathology that would render him continuously unable to care for himself. There is no indication that there is complete paralysis or this individual should not be able to care for himself from an orthopedic perspective. There is no indication why this individual required 24/7 medical care based on multiple subjective complaints, which appear to be out of proportion to his physical findings and diagnostic studies.

### **Screening Criteria**

1. Specific:

- No published screening references are available for the request for attendant treatment in this field.

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literature and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of

federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

**CERTIFICATION BY OFFICER**

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

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

IRO America is forwarding by mail or facsimile, a copy of this finding to the DWC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,  
**IRO America Inc.**

Dr. Roger Glenn Brown  
**President & Chief Resolutions Officer**

Cc: \_\_\_\_\_

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## **Your Right To Appeal**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

**I hereby certify, in accordance with DWC 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 DWC via facsimile, U.S. Postal Service or both on this 17<sup>th</sup> day of July, 2006.**

**Name and Signature of IRO America Representative:**

Sincerely,  
**IRO America Inc.**

Dr. Roger Glenn Brown  
**President & Chief Resolutions Officer**