

# **MATUTECH, INC.**

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March 20, 2006

Rebecca Farless  
Texas Department of Insurance  
Division of Worker's Compensation  
Fax: (512) 804-4868

Re: Medical Dispute Resolution  
MDR Tracking #: M2-06-0758-01  
DWC#: \_\_\_\_\_  
Injured Employee: \_\_\_\_\_  
DOI: \_\_\_\_\_  
IRO#: IRO5317

Dear Ms. Farless:

Matutech, Inc. has performed an Independent review of the medical records of the above-named case to determine medical necessity. In performing this review, Matutech reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

Matutech certifies that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him the provider, 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 Independent Review Organization.

Information and medical records pertinent to this medical dispute were obtained from Bexar County Healthcare Systems and ESIS/Pacific Employers Insurance Company. The Independent review was performed by a matched peer with the treating health care provider. This case was reviewed by the physician who is licensed in pain management, and is currently on the DWC Approved Doctors List.

Sincerely,



John Kasperbauer  
Matutech, Inc.

## REVIEWER'S REPORT

### Information provided for review:

#### Request for Independent Review

#### Information provided by Bexar County Healthcare Systems:

Office notes (09/01/05 – 02/10/06)  
Pain management notes (10/26/05 – 11/17/05)

#### Information provided by ESIS/ Pacific Employers Insurance Company:

Office notes (03/24/92 – 12/06/05)  
Electrodiagnostic studies (07/14/92 – 12/07/01)  
Radiodiagnostic studies (12/04/92 – 08/12/03)  
Therapy notes (03/16/93 – 06/26/98)  
Pain management notes (10/21/93 – 06/02/04)  
Independent Medical Evaluations (07/27/92 – 01/28/04)  
Peer reviews (02/19/03 - 08/06/03)

### Clinical History:

This is a 53-year-old female who developed pain in her neck, upper back, shoulders, and arms, due to repeated work of picking up several pairs of jeans, inspecting them, and moving them further.

**1992:** Fred Olin, M.D., noted a history of two motor vehicle accidents (MVA) one in \_\_\_\_ and the other in \_\_\_\_ in which the patient had injured her back on both occasions. She had also been involved in an MVA when she was 15 during which she suffered a fractured femur. Dr. Olin assessed chronic overuse, strain, and mild carpal tunnel syndrome (CTS). He treated the patient with Naprosyn, stretching exercises, and application of heat. Comelius Nau, M.D., a psychiatrist, diagnosed major depression secondary to chronic pain syndrome and prescribed Zoloft. Gene Smith, M.D., diagnosed left shoulder bursitis with bicipital tendonitis and administered an injection. He treated the patient with Tylenol for the lower back and neck pain. Electrodiagnostic studies revealed a very mild C6 radiculopathy on the right. In an independent medical evaluation (IME), Lawrence Lenderman, M.D., assessed cervical radiculopathy with herniated nucleus pulposus (HNP) versus thoracic outlet syndrome and recommended work modifications. Magnetic resonance imaging (MRI) of the cervical spine was unremarkable.

**1993-1994:** Dr. Smith noted left shoulder pain and prescribed a transcutaneous electrical nerve stimulation (TENS) unit, Theragesic cream, Percogesic, and Aloe-Vera liniment. He diagnosed cervical myofascial/fibrositis syndrome with depression and chronic pain. The patient underwent physical therapy (PT). A cervical myelogram was unremarkable. W. S. Avant, M.D., a neurologist, diagnosed cervical myofascial syndrome with

depression. Dr. Lenderman diagnosed myofascial pain syndrome, cervical strain syndrome, and left shoulder impingement syndrome, and recommended a steroid injection to the left subacromial bursa. The patient attended five sessions of chronic pain management program (CPMP). On June 14, 1994, Dr. Smith performed left third metatarsal condylectomy for painful plantar keratosis of the metatarsal. Dr. Smith Fergon was prescribed postoperatively. He also assessed left CTS and provided a wrist brace.

**1995-2000:** Electrodiagnostic studies suggested borderline sensory latency on the left. Harvey Rosenstock, M.D., reviewed the records and recommended psychiatric treatment for the depression. Dr. Smith continued to treat the patient with TENS unit, Aloe-Vera liniment, and Lodine. He performed left carpal tunnel release on July 17, 1995. Dr. Smith also refilled Tylenol, Naprosyn, and Soma. In 1998, he added glucosamine, chondroitin sulfate, DMSO and Theragesic cream to the medications. Thomas Crow, D.O., assessed maximum medical improvement (MMI) as of March 2, 1995, and assigned 14% whole person impairment (WPI) rating. Maury Guzick, D.O., suggested 2% impairment rating. Dr. Smith disagreed with Dr. Crow's impairment rating and suggested 19% WPI rating. The patient underwent PT. Richard Pollak, D.P.M., assessed porokeratoma of the second metatarsal head and performed debridement with Trans-Ver-Sal application. He prescribed vitamin B1 and B12. Michael Krebs, M.D., diagnosed chronic pain disorder and recommended regular follow-ups with the psychiatrist. In a functional capacity evaluation (FCE), the patient qualified at a light physical demand level (PDL). Dr. Nau continued to treat the patient with Zoloft for major depression as a complication of the chronic pain syndrome. The patient had several follow-ups with Dr. Smith who treated her with the TENS unit, Tylenol, Naprosyn, Soma, Skelaxin, Biofreeze, and bilateral wrist splints.

**2001-2002:** Dr. Smith diagnosed right CTS and left metatarsalgia. He prescribed Naprosyn, Celebrex, acetaminophen, Aloe-vera liniment, and Skelaxin. The patient had left foot complaints and had also developed atopic dermatitis in the right hand. Dr. Smith assessed recurrent plantar callosity consistent with the foot injury and gave an off work status. DMSO and a left foot pad were provided. Electrodiagnostic studies were unremarkable. In April 2002, the patient tripped on cement and fell on the left. She was diagnosed with left ankle sprain the emergency room (ER) and was given Vicodin and a knee and ankle brace. X-rays revealed healed left femur mid-shaft fracture with embedded screws and a recent left lateral tibial plateau fracture. X-rays of the left ankle were unremarkable. Dr. Smith diagnosed stable, lateral tibial plateau fracture of the left proximal tibia and recommended the use of crutches. He refilled Celebrex and added Vicodin and Darvon to the medications. An ankle support was provided. Dr. Smith also diagnosed lateral compartment arthrosis with weakness and recommended quadriceps exercises. He added glucosamine.

**2003:** In a peer review, David Trotter, M.D., rendered the following opinions. (1) The patient appeared to have been adequately treated to resolution of all the reasonable conditions associated with the injury of \_\_\_\_\_. (2) The condition appeared to be resolved and the TENS unit supplies would not apply with regards to the injury. (3) There was no evidence of any ongoing sequelae or work restrictions with regards to the

injury. (4) The patient appeared to have resolved condition years ago on or prior to March 1995. (5) The patient's ongoing condition represented a combination of pre-existent degenerations and/or injury sustained prior to the date of injury of \_\_\_\_ without any ongoing causation or chronic exacerbation.

Dr. Smith continued to treat her with Tylenol ES, Skelaxin, Celebrex, and Aloe-Vera liniment. X-rays of the cervical spine revealed rigidity at C5-C6 and loss of lordotic curvature. Dr. Hassell prescribed an RS-4i stimulator. . In a behavioral evaluation, the patient was diagnosed with adjustment disorder with mixed anxiety and depressed features, chronic, and pain disorder. A psychophysiological profile assessment was recommended.

**2004:** In another behavioral assessment, it was recommended that the patient undergo a minimum 30 days of interdisciplinary CPMP. Rita Sealy-Wirt, D.C., diagnosed tenosynovitis of the foot and ankle, rotator cuff sprain, and unspecified neuralgia/neuritis. She recommended MRI of the cervical spine and left shoulder and CPMP. A TENS unit was ordered. In an FCE, CPMP was recommended. Charles Kennedy, M.D., assessed myofascial pain and recommended an active exercise program. From February through June, the patient underwent 8 sessions of individual psychotherapy and biofeedback.

**2005:** In a psychological evaluation, it was recommended that the patient undergo an interdisciplinary CPMP. The patient underwent computerized muscle testing (CMT) and range of motion (ROM) studies. Khym Zarzuela, D.O., reviewed the findings of MRI dated February 2005, which revealed disc bulges at C2-C3, C3-C4, C4-C5, and minimal thecal sac impingement and mild posterior disc bulge at C5-C6 and C6-C7. The patient was taking Skelaxin, Celebrex, and Lexapro. Dr. Zarzuela refilled the medications and recommended CPMP with psychological support. The patient continued to have chronic pain in her upper extremities, neck, and shoulders. From October through November, the patient attended three sessions of CPMP. The patient also underwent CMT/ROM studies. In November, a request of 10 sessions of CPMP was denied since the patient had had multiple trials of individual psychotherapy and biofeedback in November 2005 and the results of a trial of antidepressants had not been documented. In a follow-up, Dr. Zarzuela assessed cervical sprain/strain and depression and recommended a participation in CPMP. He prescribed Lexapro. On December 16, 2005, he placed a request for 10 sessions of CPMP were again non-authorized for the following reasons: An inability to work was cited. Psychiatric diagnoses were not established as related to the specified work injury. The patient had improved with individual treatment. Pharmacotherapy had not been appropriately utilized. There was inconsistency in findings suggesting symptom exaggeration which had not been addressed.

**2006:** No records are available for review.

**Disputed Services:**

**10 sessions of chronic behavioral pain management program.**

**Explanation of Findings:**

The records indicate that this patient had a rather benign injury picking up pairs of jeans and inspecting them with an injury date of \_\_\_\_\_. The patient has had extensive conservative treatment including therapy. She was found to have carpal tunnel syndrome, cervical strain, and impingement of the shoulder consistent all with repetitive strain disorder. She has also had treatment for some foot complaints requiring surgery. She also had a fall in \_\_\_\_\_, sustaining a left ankle sprain and healed femur fracture. The patient has had ongoing treatment and recent records indicate a referral to a pain management program. A recent MRI studies revealed multilevel cervical degenerative disc disease. The patient has had ongoing pain for the last 13 years.

**Conclusion/Decision To Uphold, Overturn or Partially Uphold/Overturn denial:**

It is my opinion that based on evidence-based medical literature, there will be no indication for a pain management program this far out from injury. There would be no expected benefit to be established with such a program this far out from injury. The patient has had numerous attempts of therapy including psychotherapy and physical therapy. The patient is not taking any significant narcotic medications that require detoxification. However, the patient likely does have some form of depression, it is my opinion that any depression that would be related to the compensable injury would be a reactive and situational depression. It is not something which would in my opinion be prevalent at this point in time as relates to the injury itself. Therefore, there will be no indication for such a program, no reasonable benefit will be expected this far out from injury, no issues such as narcotic dependency to address and multiple attempts at similar therapy in the past.

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

ACOEM Guidelines, chapter 12.

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The physician providing this review is a physiatrist. The reviewer is national board certified in physical medicine rehabilitation as well as pain medicine. The reviewer is a member of The American Academy of Physical Medicine and Rehabilitation, International Spinal Intervention Society, American Society for Intervention Pain Physicians. The reviewer has been in active practice for 10 years.

Matutech is forwarding this decision by mail and in the case of time sensitive matters by facsimile a copy of this finding to the provider of records, payer and/or URA, patient and the Texas Department of Insurance.

Matutech retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by Matutech clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with

their particular specialties, the standards of the Utilization Review Accreditation Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by Matutech represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to Matutech for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Matutech assumes no liability for the opinions of its contracted physicians and/or clinician advisors the health plan, organization or other party authorizing this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

### 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.