



Specialty Independent Review Organization, Inc.

March 6, 2006

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

Patient:
DWC #:
MDR Tracking #: M2-06-0762-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Workers' Compensation has assigned this case to Specialty IRO for independent review in accordance with DWC 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 DWC 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

Mr. ___ suffered an injury to his right upper extremity on ___. He was working in a storage room when some boxes toppled over him. He completed an employer's first report of injury or illness reporting this injury to _____ from _____ on the date of the injury which was _____.

Mr. ___ presented to Dr. Monzer Yazji on _____ because of pain in his right elbow. He was seen 3 weeks after the accident and was reporting that his pain was getting worse. He was having difficulty holding things and noted a clicking sensation in the elbow. Dr. Gyazji noted some swelling of the elbow but no redness or warmth. He had tenderness on palpation of the elbow and elbow flexion was "abnormal, elbow extension was abnormal, pronation of the elbow was abnormal, supination of the elbow was abnormal".

He also noted that pain was elicited by movement of the elbows. He does not describe what he means by flexion and extension and pronation was "abnormal". X-rays of the elbow were obtained which were normal and Mr. ___ was referred for a MRI of the right elbow. Dr. Yazji's impression was "strained right elbow" and he recommended rehabilitation for one month and treatment with Mobic 7.5 mg once a day.

The MRI was completed on 12-15-05. This showed no evidence of a fracture, dislocation, bone bruise or bone contusion. There was excess synovial fluid within the joint space probably related to synovitis. There was no evidence of solid or cystic bony lesions. There was chronic signal alteration involving the common extensor tendon with suggestion of adjacent periostitis in the lateral aspect of the distal humerus. The appearance is probably related to chronic lateral epicondylitis.

Dr. Yazji recommended physical medicine treatment 3 times a week for 4 weeks. Mr. ___ returned to Dr. Yazji on 12-19-05. His examination was unchanged although he noted "radiocapitellar" tenderness on palpation of the right elbow. He again recommended non-steroidal anti-inflammatory medications and "orthopedic physical therapy" for one month.

Mr. ___ was evaluated by Cecil Stehr, DC, the director of rehabilitation for Edinburg Physical Medicine and Rehabilitation on 12-12-05. Dr. Stehr noted that on physical examination, Mr. ___ had normal range of motion with pain illicited in all extremes of movement of the right elbow. He also had moderate to strong pain and tenderness noted over the radial aspect of the right elbow by palpation with mild to moderate swelling and edema observed. He noted "positive orthopedic test" for epicondylitis noted by examination and a grip test was weak on the right tested by a Dynamometer. He does not define the positive orthopedic test. Deep tendon reflexes were intact and motor functions of the right elbow was "4 out of 5" manually. Diagnosis of his right elbow was sprain/strain. The treatment plan was physical medicine and rehabilitation 3 times a week for 4 weeks to include range of motion exercises, strengthening exercises such as overhead pulley, upper extremity range of motion exercises with a wand, leg raise, dumb bells and Thera-Band exercises with hot packs to be applied to the right elbow prior to exercise, to relax muscles and decrease joint stiffness. He was also to receive EMS therapy to relax muscles, increase muscle tone and strength and to prevent muscle atrophy plus ultrasound therapy to reduce pain, increase tissue healing and reduce swelling and edema. Massage therapy would be utilized to relax muscles and decrease swelling and edema.

RECORDS REVIEWED

- 1) Employer's first report of illness or injury signed by _____ on _____
- 2) Office progress notes, TWCC work status reports and correspondence by Monzer Gyazji, MD dated _____ thru 12-23-05.
- 3) X-rays of the right elbow dated _____.
- 4) MRI of the right elbow dated 12-15-05.
- 5) Physical medicine and rehabilitation initial evaluation by Cecil Stehr, DC dated 12-12-05.

- 6) Correspondence addressed to SIRO by Margo O., Edinburg Physical Medicine and Rehabilitation dated 02-17-06.
- 7) Correspondence addressed to TWCC from Attorneys S. Rhett Robinson dated 02-08-06.
- 8) Correspondence addressed to Wendy Perelli, SIRO by S. Rhett Robinson, Attorney dated 02-17-06.

REQUESTED SERVICE

The requested service is an outpatient physical therapy course of treatment 3x/week for 4 weeks consisting of therapeutic exercise, ultrasound and massage.

DECISION

The reviewer disagrees with the previous adverse determination.

BASIS FOR THE DECISION

Mr. ___ suffered a work-related injury to his right upper extremity on ___ and has had residual pain, weakness, swelling and tenderness of the right upper extremity consistent with right lateral epicondylitis. Physical therapy and rehabilitation is a standard and accepted form of treatment for this condition. The proposed physical therapy services appear reasonable and medically necessary for his type of injury.

REFERENCES

American College of Occupational and Environmental Medicine, Occupational Medicine Guidelines, second edition.

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 the reviewing provider has no known conflicts of interest 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.

Sincerely,

Wendy Perelli, CEO

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.

Sincerely,

Wendy Perelli, CEO

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 Division via facsimile, U.S. Postal Service or both on this 6th day of March 2006

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli