

August 29, 2005

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M2-05-2110-01
CLIENT TRACKING NUMBER: M2-05-2110-01 /5278

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIOA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA 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. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIOA for independent review.

Records Received:

FROM THE STATE:

Notification of IRO assignment dated 7/27/05 1 page
Texas Workers Compensation Commission form dated 7/27/05 1 page
Medical dispute resolution request/response 2 pages
Provider sheet 1 page
Table of disputed services 1 page
Fax cover sheet from Medway dated 4/26/05 1 page
Letter from Sedgwick CMS dated 4/27/05 2 pages
Letter from Sedgwick CMS dated 5/25/05 3 pages

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FROM FIDELITY & GUARANTY INSURANCE:

Letter from Downs Stanford, PC dated 8/4/05 2 pages
Letter from Sedgwick CMS dated 5/25/05 (page 2) 1 page
Letter from Downs Stanford, PC dated 7/20/05 1 page
Medical dispute resolution request/response form 1 page
Table of disputed services 1 page
Provider form 1 page
Letter from Sedgwick CMS dated 4/27/05 2 pages
Recommendation form to deny work hardening 1 page
Letter from Sedgwick CMS dated 5/25/05 1 page
Evaluation report from Healthsouth dated 2/23/05 6 pages
Work status report dated 2/23/05 1 page
Functional capacity evaluation dated 2/23/05 5 pages
Investigation summary from Spectrum investigations dated 6/22/05 7 pages

FROM DR. LOUIS ZELARELLI, DO:

Cover sheet for ___ MDR Tracking # M2-05-2110-01 1 page
Index sheet 1 page
MDR request/request for reconsideration/initial pre-authorization request 1 page
Medical dispute resolution request/response 1 page
Table of disputed services 1 page
Provider form 1 page
Fax cover sheet from Medway dated 5/18/05 1 page
Fax cover sheet from Sedgwick CMS dated 5/25/05 1 page
Letter from Sedgwick CMS dated 5/25/05 3 pages
Request for reconsideration/letter of appeal/medical necessity dated 5/18/05 1 page
Fax cover sheet from Medway dated 4/26/05 1 page
Letter from Sedgwick CMS dated 4/27/05 2 pages
Recommendation to deny work hardening 1 page
Prescription/admission criteria/treatment plan/ FCE/psych screen cover sheet 1 page
Prescription for therapy services dated 4/8/05 1 page
Admission criteria dated 5/17/05 1 page
Individualized RTW program treatment plan dated 5/18/05 2 pages
ERGOS functional capacity evaluation summary report dated 5/17/05 4 pages
Performance vs. Job requirements dated 5/17/05 1 page
Rehabilitation symptom pre-screen scoring summary dated 5/17/05 4 pages
Psycho-educational groups summary 3 pages
Physical performance evaluation (PPE) dated 4/21/04 3 pages
Physical therapy treatments cover sheet 1 page
Prescription for therapy services dated 1/3/05 1 page
PT/OT flowsheet 2 pages
Employee charting note dated 3/9/05 1 page
Employee charting note dated 3/7/05 1 page
Employee charting note dated 3/4/05 1 page
Employee charting note dated 3/2/05 1 page
Employee charting note dated 2/28/05 1 page
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Employee charting note dated 2/24/05 1 page
Employee charting note dated 2/21/05 1 page
Employee charting note dated 2/18/05 1 page
Employee charting note dated 2/16/05 1 page
Employee charting note dated 2/14/05 1 page
Employee charting note dated 2/9/05 1 page
Employee charting note dated 2/1/05 1 page
Employee charting note dated 1/28/05 1 page
Employee charting note dated 1/27/05 1 page
Employee charting note dated 1/26/05 1 page
Employee charting note dated 1/25/05 1 page
Employee charting note dated 1/24/05 1 page
Employee charting note dated 1/21/05 1 page
Employee charting note dated 1/19/05 2 pages
DDE report cover sheet 1 page
TWCC report of medical evaluation dated 4/5/05 1 page
Outpatient note dated 4/5/05 2 pages
Dr. Zegarelli's office notes cover sheet 1 page
Office notes dated 6/30/05 1 page
Office notes dated 6/14/05 2 pages
Office notes dated 5/31/05 1 page
Office notes dated 5/19/05 1 page
Office notes dated 5/4/05 1 page
Office notes dated 4/8/05 1 page
Procedure note dated 3/24/05 1 page
Office notes dated 3/10/05 1 page
Office notes dated 2/22/05 2 pages
Office notes dated 2/2/05 1 page
Office notes dated 1/18/05 1 page
Initial report dated 1/3/05 5 pages

Summary of Treatment/Case History:

According to the records, Ms. ____sustained an injury on ____ while working. She lifted up her left arm to the box prop and felt an acute pinching sensation about the left shoulder and into her neck on the left side. No trauma was involved according to the records. The patient has been treated by Dr. Louis Zegarelli who referred her to therapy comprised of electrical stimulation in a 3 time per week schedule. She also attended a 5 time per week schedule for three weeks. According to the records, Dr. Zegarelli has referred her for MRI of the left shoulder on 2/14/05, which was normal. MRI of the cervical spine was normal, and left upper extremity electrodiagnostic testing with EMG study was normal with no evidence of cervical radiculopathy. The functional capacity evaluation provided by Dr. Tonn gave an impression of the patient presenting with regional left upper extremity complaints with neither the magnitude nor the perpetuation explained by the work activity described as causal or the diagnostic and clinical evaluations to date. Dr. Tonn further states that Ms. ____presents with a clinical picture more consistent with a stress reaction and persistent stress relapsed myofascial discomfort, likely multifactorial in etiology.

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Dr. Tonn further states that this patient has no objective evidence that on or about ____, while performing her regular duties, sustained any structural damage, harm or injury necessitating lost time from work. Ms. ____ presents reporting no resolution of her symptomatology, essentially reporting ongoing in worsening symptomatology, in spite of the passage of time, the application of therapeutic modalities, and in the absence of any exposure to work tasks.

According to Dr. Tonn, this supports the conclusion that other factors besides her work are more likely causal and contributory to her subjective complaint. According to Dr. Tonn, in the absence of identifiable structural damage, harm or injury, including the absence of intrinsic shoulder or cervical pathology, and in the absence of electrodiagnostic evidence of a cervical radiculopathy or para-cervical muscle spasm, a 0% impairment rating is anticipated. Further, according to the records, on physical exam, impingement signs were negative and there was no tenderness over the acromioclavicular joint. The patient, according to the chart, has medium job requirements and usually work hardening is indicated for patients who complete functional rehabilitation and are candidates for a specific job.

Questions for Review:

1. Service in Dispute: Work Hardening Program 5 x week for 6 weeks. Medical necessity.

Conclusion/Decision to Not Certify:

1. Service in Dispute: Work Hardening Program 5 x week for 6 weeks. Medical necessity.

After careful review, this reviewer is not able to recommend work hardening for this patient due to the above stated reasons.

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

American College of Occupational and Environmental Medicine – Occupational Medical Practice Guideline 2nd Edition Chapter I

The physician who performed this review is board certified by the American College of Family Practic in Osteopathic Medicine and Surgery. This reviewer is a member of the American Medical Association, the Texas Medical Association, the American Osteopathic Association and is a Diplomate of The National Board of Examiners for Osteopathic Physicians and Surgeons of the United States of America. This reviewer has been in active practice since 1978.

MRloA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

YOUR RIGHT TO REQUEST A HEARING

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

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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 as per 28 Texas 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 as per Texas Admin. Code 102.4 (h) or 102.5 (d). A request for hearing should be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P. O. Box 17787
Austin, TX 78744

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

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA 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 MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America 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 agrees to hold MRIOA harmless for any and all claims which may arise as a result of 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.

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cc: Requestor
Respondent