

MDR Tracking Number M5-05-0310-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on July 30, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the chronic pain management program was not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above was not found to be medically necessary, reimbursement for dates of service from 01-19-04 to 03-19-04 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 10th day of November 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED DECISION

Date: November 5, 2004

RE:

MDR Tracking #: M5-05-0310-01

IRO Certificate #: 5242

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Psychiatric reviewer (who is board certified in Psychiatry) who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating

physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Notice of IRO assignment
- Table of disputed services
- CARF accreditation letter
- Health insurance claim forms
- Acumed notice of medical payment dispute
- Requester's position statement
- Letters contesting reimbursement dated 6/10/04, 5/20/04 and 4/14/04
- Letter from _____ dated 12/29/03
- Pre-authorization requests dated 1/24/04 and 5/19/04
- Records from the _____ spanning the period from 1/19/04 through 3/19/04
- _____ dated 10/7/03
- Psychological evaluation report dated 9/29/03
- Psychophysiological profile assessment not dated
- Letter of medical necessity from _____ dated 9/22/03
- Letter dated 9/4/03 from _____
- MRI of the right wrist dated 7/28/03
- MRI of the right shoulder dated 7/28/03
- MRI of the right elbow dated 7/28/03
- Retrospective peer review dated 7/17/03

Submitted by Respondent:

- TWCC-69 by _____ dated 7/16/03
- Disability determination dated 7/16/03 by _____
- Addendum to the disability determination dated 12/15/03 by _____
- Records from the _____ from 1/19/04 through 3/19/04
- MRIs as cited above dated 7/28/03 of the right wrist, right elbow, right shoulder
- Letter from _____ dated 6/10/04 with accompanying documents titled Subchapter G and Subchapter B
- Fax from the _____ dated 5/13/04
- Retrospective peer review dated 6/10/04 by _____ and _____
- Letter dated 3/31/04 from _____
- Evaluations by _____ dated 3/2/04 and 3/22/04
- Treatment notes from the _____ over the period of this claim
- Electrodiagnostic study dated 3/18/03
- Psychophysiological profile assessment not dated
- Psychological evaluation dated 9/29/03 from the _____

- Chiropractic care notes over the course of the claim
- Letter dated 8/4/03 from _____
- X-rays of the right elbow dated 6/13/03
- FCE dated 10/23/03
- Treatment notes from the _____ from the period of October 2003 through November 2003
- TWCC work status reports over the course of this claim
- Dispute of the designated doctor report dated 10/21/03 by _____
- Occupational therapy evaluation dated 9/29/03
- FCE dated 7/8/03 from the _____
- New patient consultation by _____
- Evaluations and follow up from _____ from _____ including physical therapy evaluations and occupational therapy evaluations and treatment from that same center

Clinical History

The claimant first reported pain in her right upper extremity in _____. There was no acute incident or injury. She followed up with the _____ where she was treated conservatively. An electrodiagnostic study was done by _____ who indicated that there was no evidence of radiculopathy, but there was a right carpal tunnel syndrome. He also diagnosed a lateral epicondylitis. _____ makes note that the claimant may need surgical treatment of the carpal tunnel syndrome and apparently the lateral epicondylitis is improving with conservative treatment. The claimant appears to have subsequently changed treating providers and has undergone extensive chiropractic care and physical therapy without substantial improvement. She also underwent some individual therapy and biofeedback therapy without substantial improvement. In a letter from _____ on 8/4/03, he indicates that he is going to refer the claimant to an orthopedic consult. The included documentation does not indicate the results of this evaluation or if it was accomplished. The claimant was referred to a chronic pain management program and she completed 30 days of this program from January to March 2004. From the records reviewed from the program, it does not appear that the claimant had a robust response.

Requested Service(s)

Review of the medical necessity of the chronic pain management program covering the dates from 1/19/04 through 3/19/04. It appears there was a partial remittance from 1/19/04 through 1/23/04. There was no reimbursement for the other days.

Decision

I agree with the insurance carrier that the chronic pain management program was not medically necessary.

Rationale/Basis for Decision

As to the question of whether a chronic pain management program is medically necessary to treat the symptoms that the claimant was reporting, there are a number of reasons that a chronic pain management program would not be medically necessary in this case. First of all, it appears that there is still consideration for non-tertiary levels of intervention; in particular, _____ indicates that he wanted an orthopedic consult, and there had been a prior recommendation to consider surgery by _____. Apparently the claimant was hesitant to get surgery when it was initially considered closer to the onset of her symptoms; however, it would have been reasonable to readdress this, as this would likely have been a more definitive treatment for her condition. Secondly, the effectiveness of a chronic pain management program with this type of complaint is not well established. In particular, I would reference the article Biopsychosocial Rehabilitation for Upper Limb Repetitive Strain Injuries in Working Age Adults Cochran Review in the Cochran Library issue 2/2003 Oxford Update Software by Karjalainen, K, et al.