

December 2, 2002

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2 03 0076 01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, 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 Doctor of Chiropractic who is board certified in chiropractic orthopedics. The ___ 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 ___ 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

___, a 40-year-old Hispanic woman, suffered an injury on ___ while working as a seamstress for ___, where she had worked for the previous two years. She was pulling some material when she noted a burning sensation in her right arm. She was sent by her employer to ___, he prescribed medications and returned to work in a light duty capacity. She continued at work for the next five months despite continued pain and burning. She then discontinued working on 8/19/00 and underwent 8 weeks of physical therapy/rehabilitation at ___. She then changed treating doctors to ___ on 6/1/01. ___ diagnosis was of shoulder impingement, tendinitis, myalgia and muscle spasms. A comprehensive conservative treatment regime was instituted consisting of a combination of physiotherapeutic modalities progressing to more active platform through work hardening. She had plain film x-rays of the right shoulder taken and these were read as normal on 6/6/01. On 7/10/01 an MRI of the right forearm was performed, this was also normal. MRI of the right shoulder was performed and referred to in numerous subsequent consulting physician reports as being negative for tear, positive for tendinosis, however I am not in possession of this report. She was seen by ___ for an orthopedic consult on

7/9/01. His impression was that she had an adhesive capsulitis of the right shoulder. He treated the patient with a steroid injection into the shoulder and recommended an intensive therapy program, and referred the patient back to ___ for this. Electrodiagnostic studies were performed on 8/01/01, these were unremarkable. On 8/16/01 the patient was seen for another orthopedic consult by ___. His impression was that the patient suffered a chronic impingement syndrome of the right shoulder, he recommended continued treatment with ___, along with a subacromial injection. The patient then entered into a six-week work hardening program on 8/23/01. She was assessed by a psychotherapist on 8/20/01, his opinion was that she was depressed, angry and resentful due to poor handling her accident with some sleep disturbances. The post work hardening summary identified her as being pleasant and cooperative, realistic as to what she could not to and willing to work to her maximum with a positive outlook overall. She had demonstrated minimal pain behavior and was receptive to suggestions regarding exercise, body mechanics, diet and activities of daily living. She had progressed with respect to lifting tolerance, aerobic capacity, normalized joint motion, reduction of muscle spasms and tightness, reduced pain, increased mobility, physical capacity and flexibility and decreased psychosocial dysfunction. A functional capacity evaluation was performed on 11/19/01. Pain rating was given as 3/10. The behavioral profile was negative for chemical dependency, medication or pain management substance abuse. No other psychosocial screening appears to have been performed. Otherwise movement patterns and pain behaviors correlated with subjective complaints, coefficients of variation were valid and no inconsistencies were observed. Validity criteria was summarized as giving a good validity profile, demonstrating maximal effort with the results indicating absence of an organic signs and symptoms/disability exaggeration behavior. She was placed in a sedentary to light physical demand level. The patient finally consulted with ___ for a orthopedic consult on 2/5/02. Complaints that time were of intermittent, mild achy shoulder pain. His assessment was of right shoulder tendinitis and he prescribed Arthrotech and recommended the patient continue to work at normal duty.

On 8/19/02 the treating doctor requested to a behavioral evaluation and with testing as she believed the patient suffered from significant depressive and anxiety symptoms due to her work-related injury.

REQUESTED SERVICE

The carrier has denied a Chronic Pain Management program.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

I can find no rationale for any requirement for psychological testing or evaluation of this patient in the supplied documentation.

The supplied documentation actually tends to confirm that the patient is **not** in need of these services. For all intents and purposes, the sustained injury appears to have been a relatively straightforward shoulder injury which has responded to considerable conservative physical intervention and work hardening, with some persistent pain residuals. The functional capacity evaluation in November 2001 indicated that she was progressing well. According to the most recently available documentation, (___, 2/5/02), the patient was suffering minimal symptoms without any other complicating factors or barriers to recovery reported.

The record subsequent to 02/05/02 is devoid of functional assessment or clinical indicators suggestive of any biologic, physiological, and social compromises of the patient's ability to carry out activities of daily living. *Chronic pain or chronic pain behavior is defined as devastating and recalcitrant pain with major psychosocial consequences. It is self sustaining, self regenerating and self-reinforcing and is destructive in its own right as opposed to simply being a symptom of an underlying somatic injury. Chronic pain patients display marked pain perception and maladaptive pain behavior with deterioration of coping mechanisms and resultant functional capacity limitations. The patients frequently demonstrate medical, social and economic consequences such as despair, social alienation, job loss, isolation and suicidal thoughts. Treatment history is generally characterized by excessive use of medications, prolonged use of passive therapy modalities and unwise surgical interventions. There is usually inappropriate rationalization, attention seeking and financial gain appreciation⁽⁴⁾.*

The record is absent of any indication of such behaviors to trigger a requirement for further assessment or testing. No functional and ADL activities compromises are described. These behaviors appear to be absent in this patient, in fact the reviewed record demonstrates the opposite behavioral tendencies.

Although depression has been identified in this patient, the supplied documentation suggests that any associated depression appears to have been of minimal impact. Depression on its own in the absence of other qualifiers is insufficient to determine medical necessity for extensive testing or entry into a chronic pain program.

All of the other indicators which would normally identify an appropriate candidate⁽³⁾, namely a functional capacity evaluation identifying significant psychosocial overlay and significant barriers to recovery, abnormal pain diagrams, functional reports of poor treatment participation, are absent. In fact, the record consistently reports good validity and participation in this patient. The absence of such indicators would suggest that the patient does not require any form of multi-disciplinary evaluation, much less further continuation beyond normal work hardening requirements into a chronic pain program.

Established clinical guidelines^(1,2) state that an appropriate strengthening/rehabilitation program be instituted to improve mobility and strength deficits following a course of passive care. I am unaware of any treatment guidelines that suggest a chronic pain management program be a required treatment progression in the absence of clinical indicators for such progression.

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

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

Sincerely,

References

1/ Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Gaithersburg, MD, 1993;

2/ Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997.

3/ CARF Manual for Accrediting Work Hardening Programs

4/ AMA Guides to the Evaluation of Physical Impairment, 4th Edition

YOUR RIGHT TO REQUEST A HEARING

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

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).