

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** December 4, 2003

**RE: MDR Tracking #:** M2-04-0295-01  
**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 Psychologist reviewer who is board certified in Psychology. The Psychologist 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.

### **Clinical History**

The claimant is a 43 year old female who was reportedly injured on \_\_\_ when she developed pain in her left wrist. She had reportedly developed carpal tunnel syndrome in 1996 in her right hand and began using her left hand at work until it, too, developed pain. She had a significant amount of chiropractic treatment. She reportedly also developed symptoms of anxiety and depression along with her chronic pain. There were two independent medical exams performed for her psychiatric symptoms, the first by \_\_\_ on 2/20/03 and the second by \_\_\_ on 9/25/03. They both noted the claimant suffered from these psychiatric conditions by they felt they were not the result of the compensable injury. She was referred to \_\_\_ for evaluation of her psychological condition and underwent individual psychotherapy and biofeedback. \_\_\_ then felt that her progress was insufficient and referred her to a chronic pain management program.

### **Requested Service(s)**

Chronic pain management program 5 times per week for 6 weeks.

### **Decision**

I agree with the insurance carrier that the chronic pain management program is neither medically necessary nor reasonable treatment.

### **Rationale/Basis for Decision**

The request for a chronic pain management program for the treatment of upper extremity repetitive motion injuries is unreasonable treatment because this type of treatment has not been found to be effective. Chronic pain management programs have been shown to be effective for chronic back pain but there is very little outcome literature on its effectiveness for the treatment of chronic pain resulting from upper extremity repetitive strain injuries. A study reviewing the outcomes of the effectiveness of biopsychosocial rehabilitation for the treatment of these injuries found no evidence for effectiveness (Karkalainen K, Malmivaare A, van Tulder M, Roine R, Jauhiainen M, Hurri H, Koes B. Biopsychosocial rehabilitation for upper limb repetitive strain injuries in working age adults (Cochran, Review).

In the Cochrane Library, issue 2, 2003. Oxford: Update software). Therefore, the request for a chronic pain management program for bilateral wrist pain as a result of repetitive motion injury would not be reasonable nor necessary treatment due to its lack of potential effectiveness.

### **YOUR RIGHT TO REQUEST A HEARING**

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

**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 **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

**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 **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.