

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-04-3584.M2

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0679-01

February 2, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

___, a 23 year old female, injured her lower back while employed by ___ as a cashier. She was attempting to push an entertainment center on a buggy, the buggy struck a metal rod on the floor and she fell forward against the buggy. She developed an acute onset of lower back pain with radiation into the bilateral lower extremities, right side greater than left. She subsequently developed tingling into the lateral thigh, calf and ankle. She then underwent a number of treatment modalities including physical therapy, chiropractic care, exercises, work hardening, trigger-point injections, medical medication management. MRI on 04/29/02 revealed degenerative disc disease at L5/S1 with focal posterior central disc extrusion slightly effacing the anterior dural sac. Electrodiagnostic studies on 10/22/02 were negative. The lady underwent a work hardening program in November/December of 2002 and was discharged having met four of five long-term goals, functioning at a medium physical demand capacity. She had a required medical evaluation by ___ on 2/13/03, which included a functional capacity evaluation. ___ impression was that ongoing treatment was medically unnecessary, and that she qualified for work in a light-medium physical demand category. She had a designated doctor's evaluation on 4/10/03 with ____. He felt that she was at MMI with a 0% whole person impairment.

At this time she was no longer working with ____, having changed occupations to working as a cashier in a convenience store. She continued with care including injections and on 8/26/03 had a surgical consult which recommended spinal surgery (not performed). She apparently continues with spinal pain without focal neurologic symptomatology, primarily to the lumbar spine, but also to the cervical, thoracic and right shoulder areas.

REQUESTED SERVICE (S)

Prospective medical necessity of chronic pain management program X 30 sessions.

DECISION

There is establishment of medical necessity for a chronic pain management program.

RATIONALE/BASIS FOR DECISION

The documentation provided qualifies that the patient satisfies the criteria for entry into a chronic pain management program. The AMA Guides to the Evaluation of Physical Impairment definition for chronic pain is as follows:

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.

A chronic pain program involves a multidisciplinary approach and is reserved typically for outliers of the normal patient population, i.e. poor responders to conventional treatment intervention, with significant psychosocial issues and extensive absence from work. This patient appears to fulfill these requirements

The documentation supports the patient has a Global Assessment of Functioning scale of 50, a psychosocial stressor rating of 4, has responded poorly to primary and secondary stages of treatment, exhibits pain behavior and functional limitations which disrupt her activities of daily living and is facing loss of functioning due to limitations requiring vocational, physical and psychological adjustment.

The available diagnostic findings (MRI and electrodiagnostic studies) are insufficient to explain her pain. Her pain has persisted beyond expected tissue healing time.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

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.

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 (20 Tex. 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 **20** (twenty) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

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

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 3rd day of February 2004.