

February 17, 2004

David Martinez  
TWCC Medical Dispute Resolution  
MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744-1609

MDR Tracking #: M2-04-0795-01  
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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). 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

Available documentation notes that this patient sustained injury to her left shoulder and arm while pulling a table from a wall while at work on \_\_\_. She presented to \_\_\_ for chiropractic care and physical therapy soon after injury, but only limited records of this are available for review. The patient has been diagnosed with left shoulder and lower back sprain/strain. Multiple x-rays and MRIs were performed and found essentially normal. A repeat x-ray on 5/6/03 indicated a partial tear of the rotator cuff. An orthopedic referral was made and surgical repair with bursectomy and resection of the left distal clavicle was performed on 5/22/03. Multiple pre- and post-op physical therapy sessions were performed with \_\_\_ facility in addition to six weeks of work hardening and multiple individual psych therapy sessions with biofeedback and cranio electrotherapy stimulation. No significant psychological pathology is identified. No specific vocational rehabilitation or return to work counseling appears to be made. On 12/10/03 a request was made for twenty additional sessions of a chronic pain management program to include daily group therapy, biofeedback and Alpha-Stim (Cranial Electrical Stimulation).

REQUESTED SERVICE

A twenty-session pain management program is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Medical necessity for additional chronic pain management modalities of this nature, for these conditions, is not supported by documentation and appropriate clinical protocol. There is little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation (including biofeedback, Alpha-stim and group therapy) compared to other rehabilitation facilities for neck and shoulder pain. Continuing this program, utilizing these modalities, suggests little potential for further restoration of function or ability to return to work without pain.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

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,

**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.

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 17<sup>th</sup> day of February 2004.**