

MDR Tracking Number: M2-04-1194-01  
IRO Certificate # 5259

May 17, 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 40 year old female, injured her left upper extremity, including shoulder, wrist, elbow with some involvement of the cervical spine as a result of the repetitive movements required by her occupation as a sewing machine operator. She underwent considerable conservative care measures, eventually progressing to surgery on 01/22/03, followed by an extensive postoperative rehabilitation program including injections of the left shoulder. She was discharged from the rehabilitation program on 1/14/04, apparently showing some slow but progressive improvement. She was placed at MMI by a designated Doctor on 9/17/03 with a 7% whole person impairment. She has apparently remained off work throughout her care; it appears part of this has been as a result of her worksite being shut down.

The patient was referred to \_\_\_ for a mental health evaluation on 1/20/04. The outcome of this was a recommendation for more comprehensive behavioral testing, which was then performed on 2/19/04. This identified the patient was suffering from chronic pain with elevated symptoms of anxiety and depression severely impacting normal functioning, both physically and interpersonally. Chronic pain management program was recommended

Prescribed medications include 800 mg of ibuprofen, 500 mg of acetaminophen, 10 mg cyclobenzaprine, 500 mg Tylenol, 50 mg tramadol, Advil OTC, aerobic 50 mg, Darvocet and ketaprofen 4% cream. The records are not clear as to exactly which medications she is currently taking.

#### REQUESTED SERVICE (S)

Prospective medical necessity of a pain management program five times per week for six weeks

#### DECISION

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

#### RATIONALE/BASIS FOR DECISION

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<sup>(1,2)</sup>.

*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<sup>(2)</sup>.*

The records demonstrate that the patient fulfills the above categories. The results of the psychological assessments identified maladaptive coping styles that would be best addressed in a behavioral chronic pain program.

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.

**References:**

1/ CARF Manual for Accrediting Work Hardening Programs

2/ AMA Guides to the Evaluation of Physical Impairment, 4<sup>th</sup> 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.

**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 17<sup>th</sup> day of May 2004.