

May 26, 2004

MDR #: M2-04-1258-01
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is certified in the area of Chiropractic Medicine and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: FCE, office visits, letter of medical necessity, pain management progress notes.

Information provided by Respondent: correspondence.

Clinical History:

The claimant was involved in a work-related event on ___ and over time developed pain in her hands/wrists. She was progressed through conservative chiropractic/physical therapy applications; no record of surgical applications are noted in the supplied medical records. Functional capacity evaluation performed on 08/14/03 revealed that the claimant showed signs of symptom magnification, mild signs of depression, ability to perform at a light physical demand classification (PDC), and would benefit from a psychological consult. The claimant was approved for a 4-week (20-session trial) of chronic pain management applications that occurred from on/about 01/12/04 through on/about 03/04/04.

The carrier has denied the provider's request for additional 10 sessions of chronic pain management applications.

Disputed Services:

Chronic behavioral pain management program X 10 additional sessions

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the pain management program in dispute as stated above is not medically necessary in this case.

Rationale:

The rationale of the provider to request additional trials of chronic pain management in the management of this claimant's condition is not clear from the provided medical records. There is no qualitative/quantitative data to provide sufficient medical efficacy of the previous trial of chronic pain management sessions to warrant further applications of the identical therapeutics. Specifically, in pain management, a trial of 30 sessions is reserved for claimants with severe psychosocial deficit to function. Previous assessments of this patient do not show the profound deficits of psychosocial function that would necessitate an additional 10 sessions of chronic pain management applications.

Records provided show that the claimant's global assessment of functioning (GAF) score went from 58-64. At a GAF score of 58, the claimant had some moderate symptoms or moderate difficulty in social/occupational functioning. A GAF score of 64 indicates that the claimant shows some mild symptoms or some difficulty in social/occupational function, but generally functions pretty well. The improvement noted fails to meet established criteria to allow an additional trial of 10 sessions of chronic pain management in the treatment of this claimant's condition.

The afore-mentioned information has been taken from the following guidelines of clinical practice and/or peer-reviewed journals:

Feuerstein, M. et al. *Clinical Management of Carpal Tunnel Syndrome: A 12-Year Review of Outcomes*. Am J Ind Med 1999 Mar; 35 (3): 232-45.
Overview of Implementation of Outcome Assessment Case Management in the Clinical Practice. Washington State Chiropractic Association; 2001, 54p.
Gathel, R. J. *A Bio-Psychosocial Overview of Pre-Treatment Screening of Patients with Pain*. Clin J Pain 2001 Sep; 17 (3): 192-9.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3)

This Decision is deemed received by you **five (5) 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 Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

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 May 26, 2004.

Sincerely,