



Medwork Independent Review

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DATE OF REVIEW: 10/29/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 sessions chronic behavioral pain management program (97799)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas State Licensed MD Board Certified Anesthesiology & Pain Management physician

REVIEW OUTCOME [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment to Medwork 10/10/07
2. Texas Dept of Insurance Notice of Assignment to Utilization Review Agent 10/10/2007
3. Confirmation of Receipt of a Request for a Review by an IRO 10/9/07
4. Company Request for IRO Sections 1-8 undated
5. Request for a Review By an IRO 9/25/07
6. Preauthorization Determination 8/28/07
7. E-mail 8/27/07
8. E-mail 8/27/07
9. Healthcare Request for an Appeal 8/10/07
10. Concurrent Review Determination 8/9/07
11. Treatment Plan 8/8/07
12. Misc document 8/7/07
13. Misc denial services start 8/9/07 end 9/9/07
14. Healthcare Pre-certification request 8/3/07
15. Treatment Plan 8/1/07



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16. Report of Medical Evaluation 7/25/07
17. Evaluation Report 7/25/07
18. Healthcare evaluation 7/17/07
19. Medical Remarks 12/28/06
20. ODG guidelines not provided by URA

PATIENT CLINICAL HISTORY [SUMMARY - REFRAIN FROM USING NAME]:

This is a d male, who sustained a work-related injury on xx/xx/xx involving the lumbar spine secondary to a lifting-type mechanism.

Current Diagnosis: 1) Status post two-level lumbar laminectomy; 2) Chronic back pain; 3) Chronic pain behavior.

Subsequent to this claimant's injury, he was diagnosed with a herniated nucleus pulposus at L4-5 level on the right and L5-S1 level on the left. Following conservative treatment, the claimant underwent a two-level hemi-laminectomy with fasciotomy and excision of the herniated nucleus pulposus at L4-5 and L5-S1 levels performed on June 22, 2006. The claimant underwent postoperative physical therapy for one month to include 20 sessions of a work-hardening program. Due to continued chronic low back pain, the claimant underwent a second lumbar MRI performed in December 2006, which reportedly was suggestive of postoperative mild scarring. Reportedly, the claimant had a series of three lumbar epidural steroid injections carried out in the early part of 2007 with slow improvement in pain symptoms.

In July 2007, the claimant was diagnosed with psychosocial stressors to include anxiety and depression and was recommended to undergo a chronic pain management program. Of note, the patient recently completed ten sessions of a chronic pain management program, which were approved via peer determination.

From the Appeal letter request for additional ten sessions dated August 10, 2007, the requesting provider has stated that the claimant has decreased his hydrocodone 10/500 TID usage down to BID (twice a day). Of note, there does not appear to be any progressive downward movement of claimant's depression/anxiety levels, which remain a BDI of 17 and BAI of 71.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

After review of the information submitted, the request for an additional ten session chronic pain management program has been denied.

There is a minimal reduction in narcotic medication usage and as well there is no progressive improvement of objective psychological issues to suggest that the claimant is likely achieving sustained benefit from the current requested treatment. Furthermore, there is no information provided to indicate that this patient will achieve a more favorable response from the currently requested services.

Based on the documentation provided, this request is not medically reasonable and necessary and has been not certified.

Guidelines/References Used: ACOM Guidelines 2nd Edition, chapters five and six and ODG Guidelines Treatment Index 5th edition 2006/2007 under Pain Section-Chronic Pain Programs.



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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)