



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

04/01/2008

DATE OF REVIEW: 04/01/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management (97799 CP CA 160 units/20 days)

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 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 03/12/2008
2. Confirmation of Receipt of a Request for a Review by an IRO 03/12/2008
3. Company Request for IRO Sections 1-8 undated
4. Request For a Review by an IRO patient request 03/11/2007
5. adverse determination appeal preauth UR letter 03/05/2008
6. adverse determination initial preauth UR letter 02/19/2008
7. notice of disputed issues and refusal to pay benefits 02/29/2008
Pain Recovery Center treatment plan (undated); Office note 02/28/2008; work status report 02/25/2008; Pain Recovery Center 02/13/2008; Counseling Summary Notes 02/13/2008, 02/11/2008, 02/05/2008; work status report 02/05/2008; Office Note 01/29/2008; Physical Rehab Eval 01/23/2008; Work Hardening 01/23/2008; Face Sheet 01/11/2008; Letter of referral and medical necessity 01/10/2008; work status report 12/29/2007; Office note 12/13/2007; work status report 11/23/2007; Office note 11/15/2007; work status report



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11/01/2007; Office note 10/30/2007; Dr. note & report 10/22/2007; work status report 10/15/2007; Office note 10/11/2007; Office note 10/10/2007, 10/08/2007, 10/03/2007, 10/01/2007, 09/27/2007; work status report 09/25/2007; Office note 09/20/2007; Texas WC Work Status Report 09/12/2007; Dr. letter & reports 09/12/2007; work status report 09/07/2007, 08/20/2007; Office note 08/10/2007, 08/03/2007; work status report 08/02/2007; Office note 07/19/2007; OP report 07/18/2007; work status report 07/11/2007; Office note 07/10/2007; work status report 07/05/2007; Office note 06/25/2007; work status report 06/19/2007; letter notice of disputed issues and refusal to pay benefits 06/12/2007; Office note 05/26/2007; work status report 05/25/2007, 05/12/2007; Office note 05/08/2007, 05/08/2007; work status report 04/26/2007; Office note 04/25/2007; work status report 04/24/2007; Office note 04/24/2007; work status report 04/17/2007, 04/04/2007; Pain Recovery Center letter for preauth 02/13/2007; Hospital Radiology Report 10/31/2006; Office note 10/17/2006; work status report 09/27/2006; Office note 09/04/2006; work status report 09/07/2006, 08/30/2006; work status report 08/23/2006; MD report 08/21/2006; Office note 08/17/2006; MD Rehab report 08/15/2006; work status report 08/03/2006; Dr. note 07/31/2006; Office note 07/28/2006; work status report 07/21/2006; MRI 07/15/2006; work status report 07/12/2006; Office note 07/19/2006; radiology report 07/12/2006; Employers First Report of Injury or Illness; ODG guidelines

PATIENT CLINICAL HISTORY:

This is a male who sustained a work-related injury involving his left shoulder while employed as an xxx. Subsequent to the injury, claimant was diagnosed with left shoulder impingement syndrome and eventually, following conservative treatment, required a left shoulder surgical intervention with rotator cuff repair performed on July 18, 2007. Reportedly, the patient continues to experience persistent pain from this injury and has suggestive psychosocial issues of depression/anxiety secondary to adjustment difficulties with his chronic pain. Current medication management consists of Celebrex and hydrocodone on an irregular basis for pain control. From the previously performed Utilization Review Determination dated 03/05/08, reportedly, patient has returned to work and is working modified duty up to 32 hours per week. Claimant is no longer under the care of his surgeon of which he has been apparently released. Surgical outcome documented as "good". Of note, claimant has not had any prior documented for work conditioning/work hardening and/or home program. The patient recently taken off work; no reasoning documented from requesting provider as to why.

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

After review of the information submitted, it is the opinion of this reviewer that the previous non-authorization for chronic pain management program x20 days be upheld. It appears that patient is continuing to work, or at least attempting to work and is dealing with psychosocial issues. This claimant is more likely to benefit from a work hardening program. Work hardening programs are interdisciplinary in nature with a capability of addressing the functional, physical, behavioral and vocational needs of this injured worker. Of note, previous programs/treatments



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has failed to show significant improvement for this claimant to include physical therapy, psychotherapy, and biofeedback/pain treatment.

Guidelines and References used:

1. Official Disability Guidelines.
2. American Physical Therapy Associated Guidelines.
3. ACOM Guidelines
4. Ostelo, RWJG; Van Tulder, MW; Vlaeyen, JWS; Linton, SJ; Morley, SJ; Assendelft, WJJ. Behavioral Treatment for Chronic Low Back Pain, The Cochrane Database of Systemic Reviews 2005, Issue 1 ART.CD002014 DOI:10.1002.

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 KNOWLEDGEBASE**
- 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**



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- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)**

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**