



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Workers' Compensation Health Care Network (WCN)
MEDWORK INDEPENDENT REVIEW DECISION (WCN)

DATE OF REVIEW: 08/16/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Add. Work conditioning 5xWk x 2Wks (8hrs QD) left middle finger 97545/97546

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 07/27/2010
2. Notice of assignment to URA 07/27/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 07/27/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 07/01/2010
6. letter 06/15/2010, 05/05/2010, note 06/02/2010, 05/03/2010, fax auth rqst 04/30/2010 & 04/27/2010, note & FCE 04/27/2010, note 04/26/2010, 03/26/2010 & FCE, referral 03/19/2010, note 03/05/2010, 03/03/2010, 03/02/2010, 03/01/2010, 02/26/2010, 02/25/2010, 02/24/2010, 02/22/2010, 02/19/2010, 02/18/2010, 02/17/2010, 02/16/2010, 02/15/2010, 02/10/2010, 02/05/2010, 02/03/2010, 02/01/2010, 01/29/2010, 01/27/2010, 01/20/2010, 12/16/2009, 11/19/2009, op 11/13/2009, note 10/21/2009, radiology 10/16/2009, test 10/16/2009, note 10/09/2009
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

The patient is status post injury to the middle finger, an open wound on xx/xx/xx. The patient has attended 10 sessions of a work conditioning program, the patient has better coping skills with the pain, better sleep, decreased anxiety, has pain skills, has flexibility, and increased range of motion in that finger. The patient also has increased muscle strength. The patient is still with



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some pain in the middle finger, still with some decreased range of motion, and the physician feels that more work conditioning is warranted.

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

Refer to the Official Disability Guidelines chapter on pain under work conditioning program, it states treatment is not supported for longer than 1 to 2 weeks without evidence of patient compliance and demonstrated significant gains as documented by his subjective and objective gains. The insurer's decision to deny is upheld for the request of additional work conditioning (5xWk x 2Wks (8hrs QD) left middle finger 97545/97546) as the reviewed documentation does not support the medically necessity of this request.

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)