

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

12/29/2009

REVIEW WC DECISION

DATE OF REVIEW: 12/29/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program x10 days/sessions left ankle

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

Texas State Licensed MD Board Certified Physical Medicine & Rehab physician/pain management

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 12/14/2009
2. Notice of assignment to URA 12/14/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 12/14/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 12/10/2009
6. letter 10/27/2009, 09/29/2009
7. Records 12/14/2009, 10/20/2009, 10/19/2009, records 10/08/2009, 09/24/2009, 09/23/2009, 09/18/2009, 09/15/2009, 09/10/2009, 09/08/2009, 09/09/2009, 09/04/2009, 09/02/2009, 09/01/2009, 08/31/2009, 08/28/2009, 08/27/2009, 08/26/2009, 08/25/2009, 08/24/2009, 08/05/2009, 08/14/2009, 07/30/2009, 07/14/2009, 07/02/2009, 06/23/2009, 06/22/2009, 06/19/2009, 06/18/2009, 06/17/2009, 06/16/2009, 06/15/2009, 06/11/2009, 06/10/2009, 06/08/2009, 05/21/2009, 05/12/2009, 04/16/2009, 04/15/2009, 04/11/2009, 04/03/2009, 04/06/2009, 04/02/2009, 03/19/2009, 02/12/2009, 01/15/2009
8. Records 12/18/2008, 11/13/2008, 10/16/2008, 09/18/2008, 08/07/2008, 07/25/2008, 07/18/2008, 07/17/2008, 07/14/2008, 06/19/2008, 06/13/2008, 05/22/2008, 05/21/2008, 05/19/2008, 05/16/2008, 05/14/2008, 05/12/2008, 05/09/2008, 05/07/2008, 05/05/2008, 05/02/2008, 04/30/2008, 04/28/2008, 04/24/2008, 04/25/2008, 04/22/2008, 04/21/2008, 04/18/2008, 04/16/2008, 04/11/2008, 04/09/2008, 04/08/2008, 04/07/2008, 04/04/2008, 04/02/2008, 03/31/2008, 03/28/2008, 03/26/2008, 03/24/2008, 03/18/2008, 03/19/2008, 03/14/2008, 03/07/2008, 03/05/2008, 02/04/2008, 01/28/2008, 01/25/2008, 01/23/2008, 01/22/2008, 01/11/2008, 01/08/2008
9. Records 12/13/2007, 12/21/2007, 12/19/2007, 12/04/2007, 12/07/2007, 12/06/2007, 11/30/2007, 11/27/2007, 11/20/2007, 11/16/2007, 11/14/2007, 11/13/2007, 11/09/2007, 11/08/2007, 10/30/2007,

10/23/2007, 10/22/2007, 10/17/2007, 10/15/2007, 10/10/2007, 10/08/2007, 09/27/2007, 09/26/2007, 09/25/2007, 09/21/2007, 09/20/2007, 09/14/2007, 09/13/2007, 09/11/2007, 09/07/2007, 09/06/2007, 09/04/2007, 08/28/2007, 08/22/2007, 08/17/2007, 08/16/2007, 08/10/2007, 08/05/2007, 08/02/2007, 08/01/2007, 07/31/2007, 07/19/2007, 07/06/2007, 06/05/2007, 05/04/2007, 05/01/2007, 04/13/2007, 04/05/2007, 04/04/2007, 03/20/2007, 03/13/2007, 01/30/2007, 01/25/2007, 01/12/2007

10. 12/28/2006, 11/16/2006, 11/02/2006, 10/29/2006

11. ODG guidelines were provided by the URA

PATIENT CLINICAL HISTORY:

The claimant is a male who sustained, on xx/xx/xx, an occupational fall-down injury resulting in an ankle sprain with ligament involvement. He failed conservative treatment and underwent a left ankle ligament tear repair dated April 5, 2007. He has received 20 days of a chronic pain-management program. An additional 10 days was requested.

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

The requested additional 10 days of a chronic pain-management program remains non-authorized based on the ODG guidelines. The claimant has demonstrated improvement with regard to his functional status and reduction of prescribed analgesic medication, there has been no documented substantial improvement with regard to the psychological aspect of the chronic pain-management program. The patient reported symptoms with regard to the prior May 19, 2009, report versus the September 8, 2009, report, at the 20th day of the interdisciplinary pain-rehabilitation program, remain unchanged with the exception of a minor reduction with regard to "tension" and forgetfulness. The sleep disturbance is increased. Additionally, the measure of depression, BDI II, has increased by 63% from moderate to severe. The psychological testing results at baseline at the 7th day and 20th day of the interdisciplinary pain-rehabilitation program indicate that the claimant has not reached any of his goals. Most of the measured psychological testing results are unchanged. Because the claimant has not derived benefit with regard to the psychological/behavioral aspects of the chronic pain-rehabilitation program, the additional 10 days of this program remain unauthorized, as the claimant can receive effective physical rehabilitation at a lower level of care, such as outpatient physical therapy or supervised therapeutic exercise that would allow him a greater degree of functioning. Despite the improvement of physical function from sub-sedentary to medium-heavy duty at the 20th day of the interdisciplinary pain-rehabilitation program, there is no corresponding improvement with regard to the psychological/behavioral aspect, and therefore the claimant does not require the interdisciplinary aspect of this type of program.

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)