

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

**06/24/2010**

**MEDWORK INDEPENDENT REVIEW WC DECISION**

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**DATE OF REVIEW: 06/24/2010**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

10 sessions of chronic pain management program

**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. Assignment to 06/07/2010
2. Notice of assignment to URA 06/07/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 06/04/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 05/10/2010
6. letter 04/21/2010, 04/20/2010, 04/01/2010, 01/22/2010, 01/07/2010, 10/30/2009
7. Letter of med nec not dated, note 05/18/2010, FCA 05/18/2010, note 05/12/2010, 05/06/2010, 05/05/2010, 04/26/2010, 04/22/2010, 04/18/2010, DD eval 04/16/2010, note 04/14/2010, FCE 04/14/2010, 04/13/2010, 04/08/2010, 03/29/2010, 03/26/2010, 03/12/2010, physical performance eval 03/10/2010, 03/05/2010, DD eval 02/24/2010, note 02/19/2010, 02/12/2010, 02/03/2010, 02/01/2010, FAE 02/01/2010, note 01/12/2010, 12/15/2009, 12/01/2009, 11/30/2009, 11/19/2009, radiology 11/05/2009, note 11/02/2009, radiology 10/29/2009, note 10/28/2009, 10/15/2009, 10/12/2009, 09/29/2009, radiology 09/19/2009, 09/17/2009, 09/08/2009, 09/05/2009, TDI forms 05/20/2010, 04/22/2010, 04/16/2010, 04/08/2010, 03/15/2010, 02/25/2010, 02/24/2010, 11/02/2009, 10/28/2009, 10/15/2009, 09/08/2009
8. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

Patient is status post injury, when the patient slipped and fell. According to the last medical note the patient has low back pain and coccygeal pain that is a 4 to 8 on a scale of 0 to 10. On physical examination there is tenderness with numbness in the lower extremity. Patient can not sit, stand, or lift for a long period of time. Patient is status post mental health chronic pain evaluation. He was diagnosed with chronic pain disorder with adjustment disorder. Patient's medications consist of Norco and Motrin. The patient is status post treatment cortical epidural steroid injection, physical therapy, work hardening program, and epidural steroid injection x3. MRI shows coccygeal bone bruise and x-ray shows a fracture at S1 through the coccygeal region. Request is for 10 sessions of chronic pain management program.

**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 Chronic Pain Program, states there must be extensive criteria that should be met before chronic pain program could be certified. Guidelines state that the patient should have a significant loss of ability to function independently resulting from the chronic pain and that the patient should not be a candidate for further diagnostic injections or invasive procedures. It also states that the patient's previous methods of treating chronic pain have been unsuccessful and there is absence of other options likely to result in significant clinical improvement and that the patient should exhibit motivation to change and is willing to decrease opioid dependence and forego secondary gains. The reviewed medical documentation does not support the ODG criteria for the requested 10 sessions of chronic pain management program; therefore, the previous adverse determination is upheld.

**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)