



Medwork Independent Review

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

11/16/2010

MEDWORK INDEPENDENT REVIEW DECISION (WCN)

DATE OF REVIEW: 11/16/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program 5x wk x 2wks right shoulder, bilateral leg 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 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 10/27/2010
2. Notice of assignment to URA 10/27/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 10/26/2010
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 10/25/2010
6. Re-assessment/evaluation 10/01/2010, Follow up 09/28/2010, Insurance letter 09/16/2010, Follow up 09/16/2010, Environmental Intervention 09/15/2010, Reconsideration Preauthorization 08/31/2010, Review Summary 08/10/2010, letter 08/10/2010, Review summary 08/10/2010, Preauthorization 08/04/2010, BTE Technologies 07/28/2010, Interdisciplinary Plan and Goals of Treatment, 07/27/2010, Assessment/evaluation 07/27/2010, History and Physical 07/27/2010, Physician referral 06/18/2010, Follow up 06/18/2010, Impairment rating 04/16/2010, Report of Medical Evaluation 04/16/2010, Follow up 04/16/2010, Patient Face Sheet 03/26/2010, Individual Re-assessment 02/12/2010, Initial Behavioral Medicine Consultation 11/30/2009, History and Physical 11/20/2009.
7. ODG guidelines were not provided by the URA



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PATIENT CLINICAL HISTORY:

Patient is status post injury to the bilateral secondary from a fall from a scaffold. Patient had bilateral leg trauma with subsequent surgery on both legs since that time. Date of injury was xx/xx/xx. Since that time, patient has bilateral leg pain and also had a subsequent stroke during surgery. Patient walks with a limp. On physical exam, patient has tenderness, spasm, and weakness in the bilateral legs and is on Mobic. Patient uses a cane. Patient has had a complete psychological and physical evaluation for a chronic pain program on October 1, 2010. It states that the patient is not a candidate for surgery. Patient has impaired memory, decreased appetite, restricted affect, has depressive and anxious moods, and patient has good motivation for the program. Patient has tried physical therapy, work condition, psychotherapy, biofeedback, and nothing has worked, and patient cannot return to his job.

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

Referring to the Official Disability Guidelines' chapter on pain under chronic pain management program, it states that the patient must have had a complete and thorough evaluation, that the patient has to have good motivation, and all surgical treatments have been exhausted. In review of the records submitted and the ODG guidelines, the documentation supports the request for chronic pain management program 5x wk x 2wks right shoulder, bilateral leg 97799. The patient fulfills the ODG criteria; therefore, the insurer's decision to deny is overturned.

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



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