



## Medwork Independent Review

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

**08/30/2010**

**DATE OF REVIEW: 08/30/2010**

**IRO CASE #:**

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

Chronic pain management program x10 sessions (8hrs/day 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 08/11/2010
2. Notice of assignment to URA 08/11/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 08/10/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 08/05/2010
6. SRS letter 07/02/2010, 06/08/2010, note 06/22/2010, 06/02/2010, 05/25/2010, 05/12/2010, 04/27/2010, 03/26/2010, 03/18/2009, 02/18/2009, 06/24/2008, 09/27/2007, 08/22/2007, 08/15/2007, 02/19/2007, 02/15/2007, 12/21/2005, 07/20/2005, 05/04/2005, 03/31/2005, 01/18/2005, 11/09/2004, 09/28/2004, 01/09/2004, EMG not dated, 07/25/2003
7. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

The patient has a history of low back pain since xx/xx/xx when the patient was lifting a loveseat. The patient has low back pain that radiates into the legs. On physical exam, there is tenderness with decreased range of motion. The patient is status post surgery x2, so therefore, has a diagnosis of failed back syndrome. The patient has been treated in the past, over the last 6 years, with epidural steroid injections, facet injections, psychosocial therapy, spinal cord stimulator, and surgery x2. The patient is on Ambien, Flexeril, and Duragesic. According to the notes



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reviewed, the patient has excessive dependence on health care and family members, has restlessness, decreased libido, poor concentration, confusion, and fatigue. The patient has withdrawal from social activities, insomnia, depression, and anxiety. The patient cannot do minimal tasks, cannot do ADLs. The patient has financial difficulties because she has no job, has psychosocial factors. The patient has had evaluation by the Multidisciplinary Pain Program and had a recommendation for the Chronic Pain Program.

### **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 Criteria for the Use of Multidisciplinary Pain Management Programs, it states that a patient with a chronic pain syndrome beyond 3 months, who is using prescription drugs, who has excessive on health care and/or family members, secondary physical deconditioning, withdrawal from social activities, failure to restore to pre-injury function, developmental of psychosocial sequelae are entitled to a trial of a chronic pain management program of 10 days. The patient meets the criteria in the Official Disability Guidelines chapter on Pain under Criteria for the Use of Multidisciplinary Pain Management Programs; therefore, the insurer's denial for the requested chronic pain management program x10 sessions (8hrs/day 97799) 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)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)