



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)*

08/25/2011

**DATE OF REVIEW: 08/25/2011**

**IRO CASE #:**

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

Chronic pain management program 5x wk x2 weeks (10 sessions)

**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 08/10/2011
2. Notice of assignment to URA 08/10/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 08/10/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 08/09/2011
6. Insurance 08/04/2011, 07/21/2011, 06/13/2011, 05/12/2011, 07/19/2011, 07/07/2011, 06/28/2011, 09/30/2010, Medicals 07/15/2011, 07/08/2011, 07/06/2011, 06/29/2011, 06/27/2011, 06/21/2011, 06/16/2011, 06/14/2011, 06/04/2011, 05/20/2011, 05/25/2011, 05/17/20011, 05/11/2011, 04/29/2011, 03/30/2011, 03/16/2011, 03/10/2011, 03/09/2011, 02/28/2011, 02/04/2011, 01/12/2011, 12/16/2010, 12/15/2010, 12/08/2010, 11/29/2010, 11/24/2010, 11/09/2010, 10/25/2010, 10/22/2010, 10/20/2010, 10/12/2010, 10/08/2010, 10/01/2010, 09/30/2010, 09/27/2010.
7. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**



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Patient has a history where he had injured himself at work; he fell on xx/xx/xx. Patient subsequently developed right knee pain and eventually had a knee arthroscopy. Patient still has pain that is 7 on a scale of 0-10 with tenderness and decreased range of motion in the knee. Patient had treatment with knee arthroscopy, postoperative physical therapy times 24 visits and Synvisc injections. Patient has psychological stressors consisting of depression, anxiety, poor coping skills, negative thought processes, fear of re-injury, inadequacy, poor sleep, stress, decreased self-worth, and frustration. Review request is for chronic pain management program 5x wk x2 weeks (10 sessions).

### **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 programs, it states that there must be an evaluation by the chronic pain program, and the patient has to have psychological stressors and has exhausted treatment options. Patient has had surgery and has had an evaluation by the program with the recommendation for the chronic pain program. Patient does have associated psychological stressors. In review of the records, the requested chronic pain management program 5x wk x2 weeks (10 sessions) is in support of the ODG guideline recommendations; 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)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)