



## Medwork Independent Review

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

Date: December 6, 2011

#### *MEDWORK INDEPENDENT REVIEW WC DECISION*

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**DATE OF REVIEW: 12/01/2011**

**IRO CASE #:**

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

Is chronic pain management program x80hrs treatment deemed medically necessary for this patient?

**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 11/21/2011
2. Notice of assignment to URA 11/18/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 11/18/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 11/18/2011
6. Insurance 11/07/2011, 10/31/2011, 10/18/2011, evaluations 10/17/2011, 10/12/2011,10/07/2011, treatment goals 10/07/2011, testing results 8/26/2011, medicals 07/13/2011, 11/04/2009.
7. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY**

The patient has a history of neck pain that radiates into the shoulders that is 9 on a scale of 0-10. On physical exam, there is tenderness with decreased range of motion in the neck. Patient is on Norco and Motrin. Patient has tried conservative treatment and has failed. According to the last medical note, patient has depression and anxiety with sleep disorder. Patient has a failure to



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restore to the pre-injury function level. Patient cannot do daily activities of daily living. Patient has dependence on others, family members and medical team. Patient also has fear avoidance and social withdrawal. Patient was evaluated by a psychological pain management team and was recommended for a chronic pain management program. MRI shows disk protrusion at C6-C7.

### **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 pain management programs, it states that the patient must have exhausted all methods of treatment. Patient should have had a full multidisciplinary evaluation. Patient should have psychological stressors with continued pain. Patient has all of these and meets the criteria, and therefore this should be certified; therefore chronic pain management x 80hrs is medically necessary.

### **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)