



Medwork Independent Review

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

12/29/2010

DATE OF REVIEW: 12/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic pain management program initial 10 day trial

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 12/13/2010
2. Notice of assignment to URA 12/13/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 12/10/2010
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 12/09/2010
6. Insurance letter 11/11/2010, Medical 11/11/2010, letter, 11/10/2010, Preauthorization 11/05/2010, Medicals 10/22/2010, Insurance letter 10/22/2010, Preauthorization 10/19/2010, Patient History 10/12/2010, 10/11/2010, Insurance letter 09/22/2010, Patient Face Sheet 09/16/2010, Prescription 09/15/2010, Letter 09/14/2010, Medicals 09/10/2010, History 07/12/2010, Medicals 06/17/2010, 06/09/2010, 06/07/2010, 05/25/2010, 05/24/2010, 05/21/2010, TDI forms & HCFA's.
7. ODG guidelines were provided by the URA.

PATIENT CLINICAL HISTORY:

Patient is status post injury xx/xx/xx to the wrist from repetitive work. Patient's pain is 8-9 on a scale of 0-10 with positive numbness in the wrist. Patient on physical exam has tenderness, decreased range of motion, and decreased grip strength in the hand with positive atrophy.



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Patient also has positive Phalen and Tinel signs. Patient is on Lyrica, Flexeril, and Norco. Patient has had treatment with medications and physical therapy. Patient has also associated poor sleep, anxiety, depression, irritability, forgetfulness, poor concentration, fear avoidance, and patient avoids socializing besides with his family and cannot do his activities of daily living on his own. Patient has seen a surgeon, and the surgeon feels he is not a surgical candidate, and the patient has also had an abnormal EMG. Review request is for chronic pain management program initial 10 day trial.

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 pain under chronic pain program; it states there are criteria for the use of this program. One of the criteria is that the patient must have chronic pain syndrome with evidence of loss of function that persists beyond 3 months and there has to be withdrawal from social activity. The medical records show that patient meets these. There has to be failure to restore pre-injury function and there has to be development of psychosocial sequelae, such as anxiety, fear avoidance, depression, or sleep disorders. The patient meets these as well as documented in the records. The patient has had a multidisciplinary evaluation and has been recommended for the program; therefore, referring to the OGD guidelines and the review records the insurer's denial of the requested chronic pain management program initial 10 day trial 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
- OGD- 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)**