



Medwork Independent Review

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

04/26/2011

DATE OF REVIEW: 04/26/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

80 hrs or 10 sessions of chronic pain management program

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 04/06/2011
2. Notice of assignment to URA 02/28/2011 04/06/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 04/06/2011
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 03/31/2011
6. HDI letter 03/30/2011, 03/17/2011, medicals 03/21/2011, 03/11/2011
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

Patient has an injury date of xx/xx/xx. Patient has neck pain and has had treatment of surgery. Patient has a diagnosis of failed neck syndrome. The Patient has been treated with injections, medications, and chronic pain program times 10 sessions. According to the medical notes, the patient has attended the chronic pain program times 10 days and has a decrease in depression, decrease in anxiety, and decrease in pain. The pain has gone from 8 to 6 on a scale of 0-10. The patient is motivated in the program and attends all sessions and is now working on coping skills for the pain. Review request is for 80 hrs or 10 sessions of chronic pain management program.



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

Referring to the Official Disability Guidelines, it states that there should not be an extension of the chronic pain program without the patient documented objective and subjective gains. According to the medical notation, the patient has an increase in cardiovascular activity, an increase in movement with less pain, increased range of motion, and an increase in patient's activities of daily living during the day. In review of the records along with the ODG guidelines, the patient has documented objective and subjective gains; therefore, the insurer's decision to deny the requested 80 hrs or 10 sessions of chronic pain management program 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 KNOWLEDGBASE
- 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)