



Medwork Independent Review

5840 Arndt Rd., Ste #2
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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

DATE OF REVIEW: 9/20/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Program x 10 sessions medically necessary?

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

[PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]

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. Assignment 09/08/2011,
2. Notice of assignment to URA 9/08/2011,
3. Confirmation of Receipt of a Request for a Review by an IRO 9/08/2011
4. Company Request for IRO Sections 1-3 undated
5. Request For a Review by an IRO patient request 09/01/2011
6. Insurance 8/19/2011, Medicals 8/10/2011, Insurance 8/09/2011, Medicals 8/02/2011, 7/20/2011, 07/13/2011, 07/12/2011, 06/30/2011, 04/12/2011, 02/23/2011, 02/16/2011, 02/08/2011, 11/09/2010, 08/12/2010, 07/21/2010, 07/14/2010, 05/22/2008, 04/21/2008, 04/07/2008, 06/07/2006, 05/30/2006, 05/07/2006,
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY



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Patient has a history of low back pain radiating to the left leg, left buttock, and left thigh. Patient has a diagnosis of failed back syndrome, as the patient has had a laminectomy previously. On physical exam, there is tenderness with decreased range of motion. Patient's pain is 7-9 on a scale of 0-10, and the patient also reports numbness in the lower extremity. Patient has been treated in the past with physical therapy, medications, a nerve stimulator, and surgery. MRI shows a disk bulge at L4-L5 with postoperative changes at L5 and S1. The patient is on Norco and Topamax

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

As per the *Official Disability Guidelines'* chapter on pain under criteria for the general use of multidisciplinary pain programs, it does state under the criteria that the patient has to have significant loss of ability to function independently resulting from chronic pain. It does state that previous methods of treating chronic pain have been unsuccessful, and there is absence of any other options. It does state that the patient is not a candidate for future diagnostics, injections, or invasive procedures. It also states that an adequate and thorough multidisciplinary evaluation has to have been made, including pertinent diagnostic testing. There is no documentation of any of these. Therefore, the decision to deny is upheld.

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



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- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**