Medwork Independent Review
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ACCREDITED INDEPENDENT REVIEW ORGANIZATION

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

June 11, 2012

DATE OF REVIEW: 6/11/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Chronic Pain Management Program to the left leg, left elbow, right knee and abdomen – 80 hours

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Board of Examiners of Psychologist

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. Texas Dept of Insurance Assignment to xxxxx 5/23/2012,
2. Notice of assignment to URA 5/21/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 5/23/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 5/22/2012
6. Letter from insurance – utilization group 5/14/2012, medical information 5/14/2012, letter from insurance – utilization group 5/10/2012, request for CPM program 5/9/2012, letter from insurance – utilization group 5/1/2012, medical information 4/30/2012, Letter from insurance 4/25/2012, request for 80hrs chronic pain – 4/25/2012, medical information - treatment 4/20/2012, assessment evaluation for pain management 4/20/2012, evaluation for pain 4/20/2012, psychological assessment report 3/21/2012, history and physical 2/4/2012, initial behavioral medicine consultation 4/12/2011, goals and treatment 3/23/2011, interdisciplinary pain treatment components, chronic pain management program design.

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PATIENT CLINICAL HISTORY:

This patient reportedly sustained an injury on xx/xx/xx while working as a. He was reportedly struck by a vehicle while at work injuring his left leg, left elbow, right knee, and abdomen. Several evaluations were reviewed and notes that he has had diagnostics, physical therapy, ten days of a Work Hardening program, knee surgery on 10/24/11, four psychotherapy sessions, and medications for his injury. Several psychological/behavioral medicine reports note that he rates his pain as 7/10 and is off of work. A report dated 3/21/12 notes that he has a Beck Depression Inventory Score of 6 and Beck Anxiety Inventory score of 9 with some fear-avoidance issues. An MMPI2 was reportedly valid and showed only one elevation on scale D. A BHI2 had some validity issues but reportedly demonstrated high pain focus and anxiety. He was given diagnoses of a Pain Disorder and Adjustment Disorder on a subsequent evaluation. He was reportedly taking Ibuprofen at one point and later was noted to be taking Norco, Motrin, and Tramadol.

A note from his physician, dated 2/04/12 notes that the patient should be referred back to the surgeon for a re-evaluation and that he could work modified duty. A Physical Performance Evaluation dated 4/20/12 notes that the injured employee is functioning at a medium physical demand level with a required level of heavy

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

The patient has had significant treatment for this injury. He is reporting minimal symptoms of psychological distress but high pain levels. It is not clear why he has not attempted to return to work in some capacity as he is functioning at a medium physical demand level. It is not clear on any document that the patient be referred back to the surgeon for a re-evaluation. The patient participated in work hardening but the outcome of that is not outlined. Based on the available information, the request for a chronic pain management program cannot be established as reasonable and necessary, per evidence-based guidelines; therefore, the insurer's denial 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**

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- ☐ **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)**