



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

DATE OF REVIEW: 12/6/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

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 Occupational Medicine.

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. Dept of Insurance Assignment to Medwork 11/18/2013,
2. Notice of assignment to URA 11/14/2013,
3. Confirmation of Receipt of a Request for a Review by an IRO 11/18/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 11/15/2013

Letter to IRO from insurance plan 11/18/2013, letter to IRO from physician 11/19/2013, letter requesting for certification of the medical services to law firm 11/14/2013, letter requesting for certification of the medical services 11/14/2013, letter requesting for certification of the medical services to patient 11/7/2013, request for preauthorization and concurrent review 10/30/2013, letter to insurance plan from physician 10/30/2013, letter from insurance plan 10/29/2013, letter from physician 10/28/2013, request for preauthorization and concurrent review 10/24/2013, letter from physician 10/24/2013, behavioral evaluation report 10/18/2013, work capacity evaluation 10/18/2013, operative report.

PATIENT CLINICAL HISTORY:

This is a male with history of chronic low back pain secondary to a fall incident on xx/xx/xx. The patient was treated with conservative measures, which failed to provide him lasting relief.



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He, eventually, underwent lumbar laminectomy and decompression at L5-S1 on 02/01/2013. Subsequently, he completed three weeks of post-operative rehabilitation physical therapy.

But, the patient's back pain persisted. He referred himself to Clinic for an evaluation on 10/08/13. On examination, he was noted to tenderness of the spine with restriction of range of motion. His current medications included Ultram, Motrin and Cymbalta. He was recommended mental health evaluation and functional capacity evaluation (MHA/FCE) for further assessment.

According to Behavioral Evaluation report, the patient was found to have evidence of moderate depression and pain disorder with strong psychological component. On his FCE, he was able to perform at light medium physical demand level (PDL). His job as a machinist requires heavy PDL, indicating moderate functional deficit. Based on findings, the patient was recommended to Chronic Pain Management Program for the treatment.

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

As per ODG Guidelines: Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances: "The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: Excessive dependence on health-care providers, spouse, or family; Secondary physical de-conditioning due to disuse and/or fear-avoidance of physical activity due to pain; Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; Failure to restore pre-injury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); The diagnosis is not primarily a personality disorder or psychological condition without a physical component; There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function. Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program... Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains.

This patient suffers from chronic pain syndrome with strong psychological component since last several months. He has been taking narcotic pain medication and antidepressant, without relief in



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his symptoms. His mental health evaluation provided evidence of depressed affect and chronic pain with disability behavior. On his FCE, he was found to have moderate functional deficits precluding his return to work.

An important component of chronic pain management, especially when a patient does not respond to various types of treatments, is psychological and behavioral approaches. These approaches focus on changing patient's pain behavior and enhancing patient's skills to cope with pain. A plan of care for patients with chronic pain should include: setting personal goals, improving sleep, increasing physical activity, managing stress, and decreasing pain.

Based on the patient's history and findings, an interdisciplinary chronic pain management program is indicated in his case.

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)