Medwork Independent Review
5840 Arndt Rd., Ste #2
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ACCREDITED INDEPENDENT REVIEW ORGANIZATION

NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Health Care Network – Non Worker's Compensation (HC)

December 21, 2012

DATE OF REVIEW: 12/20/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Chronic pain management – 80 hours: Dates of Service 11/06/2012 to 12/06/2012

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
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 12/05/2012
2. Notice of assignment to URA 12/04/2012
3. Confirmation of Receipt of a Request for a Review by an IRO 12/05/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 12/05/2012
6. IRO Requst 12/05/2012, letter to IRO from insurance plan 12/05/2012, letter to patient from insurance plan 11/27/2012, previous external review conducted 11/27/2012, letter to patient from insurance plan 11/23/2012, chronic pain program preauthorization request 11/21/2012, letter to patient from insurance plan 11/08/2012, previous external review conducted 11/08/2012, request for 80hrs of chronic pain management program 11/06/2012, history and physical chronic pain management program 10/31/2012, physical performance evaluation 10/31/2012, evaluation for chronic pain management program 10/08/2012, report of medical evaluation 10/01/2012, psychological assessment report 08/20/2012, patient face sheet, initial behavioral medicine consultation 07/17/2012, history and physical chronic pain management program 07/17/2012,

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interdisciplinary pain treatment components, interdisciplinary plan & goals of treatment 06/30/2011, CPMP day treatment design, report of medical evaluation.

PATIENT CLINICAL HISTORY:

The patient was involved in a work-related injury on xx/xx/xx when he was carrying a battery down some steps. He slid down the stairs, hurting several areas including shoulder, hip, knee, and back. Per office visit report, his shoulder pain had improved with therapy. He had a surgical repair of his torn ACL. He had a left thumb injury as well, which is not bothering him. Also per office visit report, he has weaned himself off of all of his narcotic medication, anti-inflammatories per the treating physician's recommendation. He has recommended a chronic pain program after exhausting therapy and work hardening.

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

Utilizing criteria by *Official Disability Guidelines*, the request for continued treatment in the form of a chronic pain management program is not established as medically necessary. The patient has completed extensive prior intervention including a work hardening program and physical therapy. The *Official Disability Guidelines* does not recommend re-enrollment in a repetition of the same or similar rehabilitation program. The patient does not have any significant psychological barriers that are manifested as depression or anxiety based on psychological exams. Several of his pain generators have improved over time and he has in fact weaned himself off of all of his medications, which is part of the program which would not be utilized. Given these findings after review of medical documentation provided, the patient is not a candidate at this time; therefore, the denial of these services 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**

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- ☐ **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)**