



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

July 2, 2013

DATE OF REVIEW: 7/2/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Pain Management 5xwk x 2wks x 80hrs.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas State Licensed MD Board Certified Physical Medicine and Rehabilitation.

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 6/12/2013
2. Notice of assignment to URA 6/7/2013
3. Confirmation of Receipt of a Request for a Review by an IRO 6/12/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 6/7/2013
Notification of reconsideration determination 6/6/2013, reconsideration chronic pain management program preauthorization request 5/22/2013, notice of adverse determination 5/20/2013, letter to patient from insurance plan 5/20/2013, request for 80 hours of a chronic pain management program 5/15/2013, medical notes 5/8/2013, 5/6/2013, plan and goals treatment plan 5/3/2013, reassessment for work hardening program continuation 5/3/2013, physical performance evaluation 5/1/2013, ODG information, work hardening daily note 4/26/2013, work hardening program daily rehabilitation worksheet 4/26/2013, group psychotherapy note 4/26/2013, individual patient coordination 4/26/2013, work hardening daily note 4/23/2013, group psychotherapy note 4/23/2013, behavioral medicine evaluation and psychiatric/psychological impairment rating 4/10/2013, medial notes 3/29/2013, letter to



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physician from department of insurance 2/11/2013, report of medical evaluation 1/26/2013, designated doctor examination data report 1/26/2013, medical notes 1/14/2013, 1/4/2013, isometric hand assessment battery form 1/4/2013, initial clinical interview and assessment 11/26/2012, operative report 6/5/2012, medical notes 2/13/2012, final report 8/3/2011.

PATIENT CLINICAL HISTORY:

The patient was injured on xx/xx/xx. She lost her grip on an air purifier and dropped it onto her right hand. She was diagnosed with a right wrist sprain and status post fusion of the scapholunate junction.

Diagnostics have included x-rays, CT scans, and MRI scans of the right hand and wrist. An EMG on February 7, 2013, was unremarkable. The MRI showed a ganglion cyst on the dorsal aspect of the right wrist.

Definitive treatment took place on June 5, 2012, where she underwent a limited arthrodesis and scapholunate fusion of the right wrist for a preoperative diagnosis of right wrist dorsal intercalated scapholunate instability deformity status post ligament tear.

Postoperatively she underwent 21 sessions of physical therapy, which, per medical documentation, did not allow her to return to her pre-surgical state and for full gainful employment.

Other treatments postoperatively include splinting and modalities such as hot packs. She had three cortisone injections into the right wrist and had preoperative physical therapy, as well.

Recently, in April 2013, she completed a 10-day trial of a work-hardening course without significant improvement. Physical demand level was determined to be sedentary, per the report on May 15, 2013, and her required physical demand level is medium.

A recent psychological evaluation on May 3, 2013, revealed a BDI of 29, revealing severe depression, and a BAI of 15, with mild anxiety. It does reveal she has a history of being placed on psychotropic medications but had side effects with the medications.

Currently she is only utilizing Advil PM to help aid in sleep disturbance and poor sleep architecture, ibuprofen 800 mg 3 to 4 times per week.

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

The determination, based on clinical information submitted for the review and using evidence-based guidelines, in particular, *Official Disability Guidelines*, further substantiates that the patient is not a candidate for a repeat of a tertiary program in the form of a chronic pain management program. Utilizing page 1072 and 1073 of the *Official Disability Guidelines*, it



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reads "neither re-enrollment and repetition of the same or similar rehabilitation program, i.e., work hardening, is not medically warranted for the same condition or injury." Additionally, the patient is not taking any medication, i.e., opioids, to warrant a weaning process or observation of a weaning process.

Additionally, a designated doctor evaluation on March 7, 2013, reveals the patient has reached MMI on January 14, 2013, with a 5% whole impairment rating.

The denial of the 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
- 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)