

IRO America Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726
Phone: 512-266-5815
Fax: 512-692-2924

DATE OF REVIEW:
MAY 19, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Office Visits and Injections for 1/5/2007

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR
OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Board Certified, American Board of Physical Medicine & 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

Case Assignment

Denial Letters

Treating Physical Progress Notes:

Comprehensive Pain Management- 11/22/2004, 3/2/2005, 5/25/2005, 8/1/2005,
1031/2005, 11/18/2005, 12/13/2005, 1/16/2006, 1/31/2006, 4/10/2006, 5/9/2006,
6/12/2006, 7/14/2006, 8/14/2006, 9/11/2006, 10/02/2006, 11/06/2006,
Claim Detail

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient injured her back when moving a washer and dryer. She has been somewhat stable with medical management. She has had intermittent flares of pain unresponsive to her oral medication regimen, for which she has been treated with IM injections of Toradol and Norflex. The treating physician notes that these have averted some emergency room visits.

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

This Patient has had ongoing office visits for medical management of her chronic pain syndrome, with occasional appropriate injections of IM Toradol and Norflex. The above disputed medical care for an office visit and Toradol and Norflex injection is reasonable and the carrier should be responsible for paying it as it was medically necessary.

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)