

# **RYCO MedReview**

## **Notice of Independent Review Decision**

### **IRO REVIEWER REPORT – WC (Non-Network)**

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**DATE OF REVIEW:** 12/19/07 (REVISED 12/27/07 AND 01/09/07)

**IRO CASE #:**

#### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Four follow-up office visits (99214) over 12 months

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

Board Certified in Orthopedic Surgery

#### **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.

Four follow-up office visits (99214) over 12 months – Upheld

#### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

An ambulance report

An Emergency Room report from an unknown provider (signature was illegible)

X-rays of the pelvis, left hand, and lumbar spine interpreted by M.D.  
A CT scan of the brain interpreted by M.D.  
An Employee's Report of Injury form  
An Employer's First Report of Injury or Illness form  
Evaluations with D.O. dated 06/21/05 and 06/27/05  
TWCC-73 forms from Dr. dated 06/21/05 and 06/22/05  
An evaluation with M.D. dated 06/22/05  
An evaluation with P.A.-C. and M.D. dated 06/27/05  
TWCC-73 forms from M.D. dated 07/01/05, 07/15/05, 07/18/05, 07/29/05, 08/19/05, 09/27/05, and 12/06/05  
Evaluations with Dr. dated 07/01/05, 07/15/05, 07/29/05, 08/19/05, 09/27/05, and 12/06/05  
Evaluations with M.D. dated 07/12/05 and 07/25/05  
A TWCC-73 form from Dr. dated 07/12/05  
An evaluation with M.D. dated 07/12/05  
An evaluation with an unknown provider (signature was illegible) dated 07/18/05  
An MRI of the lumbar spine interpreted by M.D. dated 07/20/05  
Evaluations with M.D. dated 08/10/05, 09/19/05, 10/13/05, 10/17/05, 12/05/05, 01/16/06, 02/27/06, 04/13/06, 04/17/06, 05/25/06, 07/12/06, 09/19/06, 12/05/06, 08/09/07, 08/27/07, 09/26/07, and 11/01/07  
A TWCC-73 form from Dr. dated 08/10/05  
A lumbar myelogram CT scan interpreted by M.D. dated 09/14/05  
A lower extremity EMG/NCV study interpreted by M.D. dated 09/26/05  
Letters of appeal from Dr. dated 09/28/05 and 11/26/07  
Physical therapy was performed (no credentials were listed) and Dr. dated 10/03/05, 10/06/05, 10/07/05, 10/10/05, 10/12/05, 10/18/05, 10/19/05, 10/24/05, 10/26/05, 10/27/05, and 11/02/05  
Epidural steroid injections (ESIs) with Dr. dated 01/23/06, 03/03/06, 09/06/07, 09/21/07, and 10/10/07  
A physical therapy evaluation with P.T. dated 12/21/05  
Physical/occupational therapy notes from Ms. dated 01/17/06, 01/19/06, 01/20/06, 01/24/06, 01/26/06, 01/31/06, 02/02/06, 02/03/06, 02/09/06, 02/13/06, 02/17/06, and 02/22/06  
A Required Medical Evaluation (RME) with M.D. dated 02/24/06  
A DWC-73 form from Dr. dated 02/24/06  
A Functional Capacity Evaluation (FCE) with O.T.R. dated 03/23/06  
An impairment rating evaluation with M.D. dated 06/15/06  
ESIs with M.D. dated 10/03/06 and 12/05/06  
An evaluation with P.A.-C. for Dr. dated 01/26/07  
A prospective review from M.D. dated 05/29/07  
An MRI of the lumbar spine interpreted by Dr. (no credentials were listed) dated 8/20/07  
An evaluation with Psy.D. dated 09/21/07  
Letters of preauthorization request from Dr. dated 09/26/07 and 10/23/07  
Individual psychotherapy with Dr. dated 10/09/07, 10/16/07, and 10/23/07  
A preauthorization request from Dr. dated 10/27/07  
Letters of non-certification, according to the ODG Guidelines, dated 11/26/07 and 11/30/07

An undated preauthorization request from Dr.  
The ODG Guidelines were not provided by the carrier or the URA

**PATIENT CLINICAL HISTORY [SUMMARY]:**

X-rays of the pelvis, left hand, and lumbar spine interpreted by Dr. revealed an avulsion fracture in the third finger of the left hand and a prior lumbar surgery at L4 through S1. An MRI of the lumbar spine interpreted by Dr. on 07/20/05 revealed surgical changes at L5-S1 with disc desiccation and mild degenerative end plate changes. A lumbar myelogram CT scan interpreted by Dr. on 09/14/05 revealed pseudoarthrosis at L5-S1 with a recurrent or residual disc protrusion. On 09/19/05, Dr. recommended lumbar facet injections, Tramadol, Relafen, Robaxin, weight loss, and physical therapy. An EMG/NCV study interpreted by Dr. on 09/26/05 revealed an L4 and S1 radiculopathy on the right. Physical therapy was performed with Ms. and Dr. from 10/03/05 through 11/02/05 for a total of 11 sessions. On 12/05/05, Dr. recommended active physical therapy and lumbar epidural steroid injections (ESIs). Physical therapy was performed with Ms. from 01/17/06 through 02/22/06 for a total of 12 sessions. Lumbar ESIs were performed by Dr. from 01/23/06 through 10/10/07 for a total of five injections. On 02/24/06, Dr. recommended no further treatment or medications. An FCE with Ms. on 03/23/06 indicated the patient should have a work hardening program. On 06/15/06, Dr. placed the patient at Maximum Medical Improvement (MMI) with an 8% whole person impairment rating. On 09/19/06, Dr. recommended lumbar ESIs. On 05/29/07, Dr. recommended continued office visits and Tramadol. On 08/09/07, Dr. recommended an MRI of the lumbar spine, Tramadol, Flexeril, Lyrica, and Celebrex. An MRI of the lumbar spine interpreted by Dr. on 08/20/07 revealed only mild stenosis at L5-S1. On 09/21/07, Dr. recommended individual psychotherapy. Individual psychotherapy was performed with Dr. on 10/09/07, 10/16/07, and 10/23/07. On 10/23/07, Dr. requested continued follow-up visits. On 11/01/07, Dr. requested a chronic pain management program. wrote letters of non-authorization for further office visits on 11/26/07 and 11/30/07.

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

This is an unfortunate woman, who has had surgery for uncertain indications. While the surgery was technically successful, that is she had healing of the fusion, she has continued with a myriad of complaints. She has been following with Dr. for some time. She has been evaluated by a chronic pain management program that Dr. is the medical director of. The purpose of this pain management program, as the medical director would know, is to minimize the amount of medication and the amount of follow-up visits necessary. Therefore, the necessity for four office visits (99214) over 12 months has not been established and would not be reasonable or necessary.

Criteria utilized is the Official Disability Guidelines for Treatment of Worker's Compensation, 2006, web-based edition, as well as my knowledge of the patient's prior surgery and review of the available records.

**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)