

Applied Assessments LLC

*An Independent Review
Organization*

1124 N. Fielder Road, #179, Arlington, TX
\\

(512) 772-1863
(phone) (512)
857-1245 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: 07/03/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient office visit on 02/19/08.

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

M.D., Board Certified in Pain Management and Anesthesiology under the American Board of Anesthesiologists.

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)

Upon independent review the reviewer finds that the outpatient office visit on 02/19/08 was medically necessary.

Date of Injury	Type of Review	Service Begin Date	Service End Date	Primary Diagnosis Codes	Service Being Denied	Units of Service	Upheld/Overturned
	Retro	2/19/08	2/19/08	722.83, 724.2, 724.4, 722.10	99213	1	Overturned

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male patient being treated for low back pain. It was noted that a previous peer review stated that the patient should only need to follow up with his primary care physician once every three months for his pain. It is noted though that the patient received a caudal epidural steroid injection on 02/07/08. The patient was reevaluated to assess his response to this caudal epidural steroid injection on 02/19/08. The current retrospective review is for the medical necessity of the outpatient office visit which took place on 2/19/08.

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

Upon independent review of the provided medical records and ODG Guidelines, this reviewer finds that retrospectively the outpatient office visit on 02/19/08 was medically necessary. I am aware through review that there was a peer review report dated 11/18/07 that stated the patient only needed follow-up office visits once every three months with his primary care physician. However, this patient had a caudal epidural steroid injection approved and thus needed to have the results assessed. This is standard medical practice. Therefore, the office visit that occurred on 02/19/08 was appropriate and 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)**