

Applied Resolutions LLC

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 03/10/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

One Pain Management Consultation (99245), with three medication follow-ups (99244)

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

M.D., Board Certified in Anesthesiology with Certificate of Added Qualifications by the American Board of Anesthesiology in Pain Management, in practice of Pain Management since 1980.

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 there is no medical necessity demonstrated for one Pain Management Consultation (99245) and three follow-up visits (99244).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination letters, 12/26/07 and 01/07/08
ODG Guidelines and Treatment Guidelines
Notes from DC, 02/26/08, 01/31/08, 01/03/08, 12/05/07, 12/26/07, 01/10/08
Position Statement from URA, 02/25/08

Independent Medical Evaluation by Dr., 10/09/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This individual was injured in xxxx and underwent a two-level cervical fusion after failure of conservative care. He was seeing a pain management physician who deemed that medications were unnecessary. He is working part-time, and video surveillance revealed a discrepancy between his behaviors while seeing the provider versus when he is on his own. Dr. IME indicated exaggeration of symptom complaints and recommended no further treatment.

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

Per the ACOEM and ODG Guidelines, care should be provided at the lowest levels of acuity. This individual has been deemed to require no medications and no further treatment. The treatment recommended by the chiropractic provider is unnecessary. The Independent Medical Evaluation revealed that no additional treatment is required.

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)**