

# P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

## Notice of Independent Review Decision

**DATE OF REVIEW:** 3/27/09

**IRO CASE #:**

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

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

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

99215 Office or Outpatient Visit; established

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overtuned (Disagree)

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

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o August 10, 2007 Lumbar MRI read by Dr.
- o June 3, 2008 Medical report from Dr.
- o July 15, 2008 Medical report from Dr.
- o July 25, 2008 Medical report from Dr.
- o August 12, 2008 Medical report from Dr.
- o January 13, 2009 Adverse determination letter from IMO
- o February 2, 2009 Medical report from Dr.
- o Undated Letter from Dr.
- o February 11, 2009 Adverse determination letter for reconsideration from IMO
- o February 17, 2009 Letter from Dr.
- o March 17, 2009 Request for IRO
- o March 20, 2009 Notice of Case Assignment

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records submitted for review, the patient is a employee who sustained an industrial injury to the low back on xx-xx-xx. Lumbar MRI performed August 10, 2007 shows diffuse disc dessication consistent with degenerative disc disease between L2-3 and L5-S1. Moderate right neural foraminal stenosis at L4-5 and L3-4 secondary to a disc osteophyte complex.

The patient was examined on June 3, 2008 and noted to have a history of chronic low back pain and L5-S1 radiculopathy. He feels his back pain is getting worse and reports radiation of pain into the right leg. On examination, lumbar range of motion is restricted and tenderness is appreciated. Straight leg raise is negative. Lower extremity strength and reflexes are normal. He had a nerve conduction test that corroborated his left leg symptoms, showing L5-S1 radiculopathy. He will be sent for a neurological evaluation.

The patient is seen next on July 15, 2008 for his right knee injury. He wants more medication for his persisting right knee pain. There is some tenderness over the medial joint line and no swelling. He is given a prescription for Celebrex and topical creams.

A letter from the provider dated July 25, 2008 indicates the patient has been sent to a neurologist for consideration of lumbar epidural injections which have been helpful in the past. He has an exacerbation of his chronic lumbar condition and required occasional visits for maintenance and injections and/or medications. He should be afforded follow-up visits and medications for flare-up of his symptoms.

The patient was reevaluated on August 12, 2008. He is taking medication for internal derangement of the right knee from an injury of October 2002 and is status post medial meniscus repair in August 2002. He has a history of herniated disc at L5-S1 with radiculopathy. He has been recommended to see a neurologist. Examination of the knee shows no ligamentous laxity.

Request for office visits in 2-3 months for medication review was not certified in review on January 13, 2009 with rationale that the patient is now 6 months post injury and the medical records fail to document prescription medications related to this injury. Even if prescription NSAIDs were allowed, there would not be a medical necessity for office visits every 2-3 months per guidelines.

The provider responds on February 2, 2009. The patient has chronic lumbosacral strain and radiculopathy of L5-S1 and a history of coccygodynia. Straight leg raise is pain-free to 90 degrees on the right. He has strong flexion and extension of both hips, knees and ankles and has normal sensation in both legs and feet. There is pain in the lower back with palpation and it radiates into the right thigh. He is a and has been able to work with use of a Sacro-Eze support seat, topical medications and Celebrex. He has not had good luck with over-the-counter medications in the past. He has also been recommended for a neurosurgical evaluation to see if he could benefit from neurosurgical treatment.

Request for reconsideration of return office visit in 2-3 months was not certified in review on February 11, 2009 with rationale that the medical records fail to clarify the mechanism of injury. The claimant has undergone surgery for his meniscal tear in 2003. He remains on Celebrex and a compounded topical cream with Ketoprofen and Flexeril. He has a history of L5-S1 disc herniation with radiculopathy of June 2007 and a right knee injury of October 2002. The provider was not able in conversation to provide any additional clinical information to warrant the request. The medications being provided are not supported by The Official Disability Guidelines. NSAIDs such as Celebrex are not noted to be efficacious for pain or function in chronic pain. The provider does not clarify the specific necessity of the selected medications versus over-the-counter alternatives. The compounded medication ingredients of NSAID and muscle relaxer are not supported by The Official Disability Guidelines. This obviates the necessity for additional office visits.

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

Per ODG office visits are recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. While the current medications may not be the most appropriate, the patient has chronic residuals from industrial injuries to the knee and low back that warrant occasional recheck for flare-up management or other concerns. The need to reassess current medications itself indicates a need for an office visit. Additionally, the patient is able to continue working with aid of an ergonomic seat support which may need replacement at some point. Therefore, my recommendation is to overturn the previous non-certification for 99215 office or outpatient visit; established return visit in 2-3 months.

The IRO's decision is consistent with the following guidelines:

#### **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 KNOWLEDGBASE

\_\_\_\_ 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

The Official Disability Guidelines - Updated 3-17-2009:

99215 Office/outpatient visit, est

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

#### OFFICE VISITS:

Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy.