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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/03/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Office Visit 99214

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Peer Reviews: 01/15/09 & 02/03/09

ODG Guidelines and Treatment Guidelines

Lumbar Spine MRIs: 01/04/01, 02/17/04 & date illegible x1

Dr. -- Office Records:

08/14/04, 09/20/04, 10/18/04, 11/15/04, 12/03/04; 12/27/04; 01/03/05; 03/24/05; 05/04/05; 07/06/05; 07/27/05; 08/10/05; 08/31/05; 09/19/05; 09/26/05; 10/05/05; 11/16/05; 11/23/05; 12/23/05; 01/23/06; 02/20/06; 03/22/06; 04/28/06; 05/31/06; 06/14/06; 07/25/06; 08/18/06; 09/11/06; 10/09/06; 10/16/06; 11/15/06; 11/29/06; 12/01/06; 01/17/07; 04/18/07; 07/18/07; 10/22/07; 01/21/08; 07/21/08; 01/14/09

Lumbar Spine X-rays: 11/18/04; 11/01/05

Dr. -- Procedure Reports: 11/18/04; 04/19/05; 08/04/06; 10/30/06; 01/04/07

Chest X-rays: 09/27/05

Hospital Discharge Note: 11/04/05

Operative Report: 11/02/05

PATIENT CLINICAL HISTORY SUMMARY

This xx year old male sustained on injury while working. Documentation revealed the

claimant underwent a lumbar discectomy in 06/01 and a re-do decompression of L5-S1 in 02/04. Postoperatively the claimant continued with low back pain and left lower extremity pain and was diagnosed with lumbar internal disc derangement, lumbago, lumbar radiculopathy and epidural seroma and subsequently underwent a re-do left L4-5 and L5-S1 hemilaminectomy with re-exploration of L5 and S1 nerve root and a right L3-4 and L5-S1 hemilaminectomy with an anterior interbody fusion of L4-5 and L5-S1 with cage and a posterior instrumentation of L4 through S1 on 11/01/05. Postoperative care included a thoracolumbosacral orthosis, a bone growth stimulator, medication management and physical therapy. Office records dated 05/31/06 revealed a complete fusion on x-rays. The claimant underwent bilateral L3-4 facet injections on 08/04/06 and 10/30/06 for symptom flare ups which were effective in reducing the claimant's symptoms and provided improved range of motion and increased activity with decreased medication usage.

On 11/29/06 follow up the claimant reported continued pain in his lumbosacral region which was greater on the left and a diagnosis of left sacroiliitis was noted. The claimant underwent a left sacroiliac joint injection on 01/04/07 which provided 50 percent relief of his symptoms. The office visit of 07/21/08 documented that the claimant had returned to a high level of function and all activities of daily living with intermittent medication usage of Celebrex and Ultracet. Dr. documented that the claimant experienced posterior thigh cramping usually in the evening on a daily basis. Examination revealed good lumbar range of motion. Dr. advised the claimant to use Neurontin, observe good body mechanics and continue with activities of daily living.

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

The request for level 99214 cannot be recommended. The documentation indicates that the examination qualified for 9 bullets and the history qualified for 3 bullets. To code for office visit 99214, 12 examination bullets and 4 history bullets would be required which is not supported in this case. The patient does not meet the guidelines. The reviewer finds that medical necessity does not exist for Office Visit 99214.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)