SENT VIA EMAIL OR FAX ON
Apr/20/2010

Pure Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

Amended 4/21/10 (Injury Date)
Date of Notice of Decision: Apr/20/2010

DATE OF REVIEW:
Apr/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
One office visit with C.P. Garcia, MD got management of medication and monitoring lower back pain as an outpatient

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

REVIEW OUTCOME:

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

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 3/3/10 and 2/18/10
xxxxx 12/8/09 thru 3/29/10
Diagnostic 6/19/09
Radiology Report 8/10/09
Pain 12/10/09

PATIENT CLINICAL HISTORY SUMMARY

This is a woman injured in xx/xx. She underwent a fusion at L4/5 in 7/07 with hardware removal in 1008. He current medications include hydrocodone, Lexapro and Flexeril. She had a recent CT myelogram 8/09 that showed possible left sided L3/4 root compromise in the lateral recess and neural foramen. An EMG was cited as showing chronic radiculopathy based upon tibial and peroneal F reflex and H wave abnormalities, but the actual study was not provided. The issue appears to be the need for monthly office visits rather than visits every 4 months per an IME. That report was not provided. The records note the consideration of possible surgery vs. ESIs.

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

The request appears to be for a policy rather than a specific office visit. The issue of the appropriateness of the office visits can be based upon a personal feel for the patient and situation. The denial is based upon an IME that the Reviewer did not have to review. Dr. wrote, "Monthly office visits are medically necessary to monitor progression or deterioration of her condition." The records presented since last summer suggest there were changes. Otherwise, why would the CT myelogram have been ordered or approved. The same goes for the EMG. The records, however, do not show any change from month to month in symptoms. Offsetting this is the ongoing use of hydrocodone a controlled substance. Federal and State laws and regulations require adequate supervision by the prescribing doctor. This appears to be Dr. Both Dr. and Dr. appear to be involved as pain doctors. Their frequencies of office visits have significant overlay and do have bearing on frequency of visits.

The ODG addressed this in different sections. First is the role of "medically necessary." That, like beauty, can be in the eye of the beholder, or as the ODG states "reasonable physician judgment." This is based on medications such as opiates. The ODG addresses the chronic use of opiates saying office visits should be every 1-1/2 to 2 months, but also states that California regulations do consider monthly visits reasonable. In a third section, the ODG does recognize the range from 1-6 months.

Therefore the ODG does support the monthly office visits while there are ongoing and unstable problems.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)