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Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 06/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
99213 – Office visit to Comprehensive Pain Management on 01/13/10

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The TMF physician reviewer is board certified in pain management with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the 99213 – Office visit to Comprehensive Pain Management on 01/13/10 was medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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PATIENT CLINICAL HISTORY [SUMMARY]:
This patient sustained a work related injury on xx/xx/xx when he fell and struck his back on a storage box. The documentation from the pain management progress notes indicate that the patient is complaining of pain located in the back and tailbone/buttock area. He is being treated with medications. The provider has had the payment for the office visit of 01/13/10 denied.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
This injured worker is experiencing chronic back pain following a work related injury. There is spondylolysis but no mention of prior back pain. Surgery for this patient is not indicated and he is being maintained on potent (schedule 2) opiates. There is documentation in the office visit notes that the medication is enhancing his comfort and functionality. The standard of care dictates that close monitoring is required and office visits every 4-6 weeks would be appropriate. Therefore, it is determined that the office visit of 01/13/10 would be medically necessary to treat this patient's condition.

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)