



## Notice of Independent Review Decision

**DATE OF REVIEW:** 05/28/10

**IRO CASE #:**

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

Office Visit – 99213

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

Licensed in Chiropractics

### **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.

Office Visit – 99213 - OVERTURNED

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

- Initial Evaluation, D.C., 11/06/07
- Designated Doctor Evaluation (DDE), M.D., 08/07/08

- Initial Evaluation, M.D., 04/21/09, 05/19/09
- Peer Review, D.O., 05/14/09
- MRI Lumbar Spine, M.D., 06/17/09
- Correspondence, Dr., 11/17/09
- Progress Evaluation, Dr., 11/17/09
- Request for Reconsideration, D.C., 11/19/09
- Correspondence, Unknown Provider, 11/20/09
- Follow up Evaluation, Dr., 12/09/09, 02/04/10
- Rebuttal Letter, Dr., 12/18/09
- Pre-Authorization Request, Dr., 03/16/10
- Denial Letter, 03/31/10, 04/15/10
- Rebuttal of Peer Review, Dr., 04/02/10
- Physical Therapy Request, Dr., 04/13/10
- DWC Form 73, Dr., 04/13/10
- The ODG Guidelines were not provided by the carrier or the URA.

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient was injured when he lifted a gas cylinder that weight approximately 35 pounds. As he was lifting, he felt a “pop” in his low back, followed by a burning pain. Initially, he treated at the hospital and placed on light duty for several days. It appeared that he had undergone therapy for approximately one month with no improvement. It was noted he had undergone a lumbar Epidural Steroid Injection (ESI) with initial benefit; however, the benefit was short-lived. An MRI was performed which showed a posterior protrusion at L4-L5 and L5-S1. There was a subligamentous disc herniation measuring 2.5-3 mm in diameter. He appeared to be treated with Darvocet N 100/650 mg, Gel # 10 and Naproxen 500 mg. On 11/20/09, all his medications were denied, due to a Peer Review indicating the medications were no longer reasonable and necessary. The Preauthorization Determinations state the patient is now status post-op as of early March, though no surgical records were included for my review.

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

Dr. is the patient’s treating physician. His job is to coordinate care with regard to his patient until such time as he is no longer the treating physician and he should be allowed to see his patient to monitor care, assuming the claimant still needs to be under care, which becomes a different criteria once a patient has been placed at Maximum Medical Improvement, obviously, and given a whole body percentage of permanent impairment. As such, Dr. should be able to monitor his patient's care via the requested office visit. The definition for a treating doctor with regard to the TDI Division of Worker’s Compensation is the doctor who is primarily responsible for the employee’s healthcare for an injury and per the records reviewed, that would appear to be Dr..

Regarding the Official Disability Guidelines on this topic, it indicates that evaluation and management of office patient/outpatient visits play a critical role in the proper diagnosis and return to function of an injured worker and they should be encouraged, and that the need for a clinical office visit with the healthcare provider is individualized based upon review of the patient's concerns, symptoms, stability, and reasonable physician adjustment. The Official Disability Guidelines find that this is an important part of monitoring and managing a patient's care. Therefore, my finding is for allowing the office visit 99213 with Dr..

**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)**