



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 8/25/2011

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a follow-up visit (95615).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

**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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a follow-up visit (95615).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

According to available medical records, this worker was injured on xx/xx/xx while bending or squatting down to place an object on a low rack. He felt a pop in his back and pain in his right leg. He was initially referred to the Clinic for evaluation and early treatment although the available medical records do not describe his early treatment. He underwent electromyographic studies on April 14, 2010 and these showed no evidence of a lumbosacral radiculopathy.

On May 21, 2010, the injured worker began treatment with D.C. He also was treated concurrently by M.D. Dr. in what was described as a “subsequent evaluation” on June 22, 2010 gave the impression that the injured worker had a lumbar strain with pain radiating posteriorly down the right thigh and radiculitis. He recommended a MRI, 12 physical therapy sessions, Soma, Vicodin, and Lexapro.

A Designated Doctor Evaluation by M.D. on June 22, 2010 revealed that the injured worker had a diagnosis of lumbar strain and pain. He was determined to be at maximum medical improvement on that date with 0% whole person impairment.

The injured worker continued to be followed by both Dr. and Dr.. MRI scanning demonstrated multilevel disk protrusions. An orthopedic consultation was obtained and surgery was recommended, but not approved. Records indicate that the injured worker entered a chronic pain management program sometime in the spring of 2011. There are no records labeled as being a part of the chronic pain management program. Dr. last evaluated the injured worker on May 31, 2011 and noted that he was complaining of increased lower back pain radiating posteriorly down the right thigh. Treatment with Xanax, Fioricet, Soma, and a TENS unit was recommended. Apparently, further evaluation visits by Dr. have been denied by the insurance carrier and the injured worker’s care and treatment after Dr. visit is not described in the medical record.

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

Records reviewed indicate that this worker had a work related injury to his lumbar spine on xx/xx/xx. He received initial treatment at Clinic, but this is not described in the medical record. He was subsequently treated by Dr., a chiropractor and a,

M.D. According to the medical records provided, Dr. did provide some therapy to the injured worker although this is not entirely clear in the medical record. Dr. followed the injured worker throughout the course of his care and treatment on a four to six week basis providing medications and further recommendations for therapy.

These medications included narcotic analgesics, Xanax, muscle relaxers, antidepressants, and a Lidoderm patch.

Surgery was recommended for the injured worker, but apparently denied by the insurance carrier. The injured worker then entered a chronic pain management program, but there are no records describing the treatment received in the program.

At present, Dr. is requesting approval for a follow-up visit. Dr., in his last visit of May 31, indicated that the injured worker's pain was getting worse in spite of his chronic pain management program and aggressive medication management.

The chart does indicate that the injured worker was taking controlled substances and was being followed routinely by Dr. in order to manage those medications and monitor the progress on the medications.

According to ODG Treatment Guidelines, office visits are recommended as determined to be medically necessary. While six follow-up visits are recommended for a lumbar sprain without documented radiculopathy, the Guides clearly indicate that the need for a clinical office visit is individualized based upon the review of the patient's concerns, signs, symptoms, clinical stability, and reasonable physician judgment.

It appears from this medical record that the injured worker was not clinically stable since in spite of his multiple medications and chronic pain management program, he was reporting worsening symptoms at his last evaluation. In addition, he was taking controlled substances that should be monitored closely by a physician. In order to obtain the desired outcome of treatment and to help this injured worker achieve independence from the health care system, it is medically necessary for this injured worker to have a follow-up visit with his treating physician to determine how his unstable condition and medication regime should be managed.

**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)