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Notice of Independent Review Decision

DATE OF REVIEW: 06/02/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Item in dispute: OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: -AN EXPANDED PROBLEM FOCUSED HISTORY;
DATES OF SERVICE FROM 05/23/2011 TO 05/23/11

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas Board Certified Physical Medicine & Rehabilitation

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW
1. Clinical notes dated 07/27/95 to 04/11/11.
2. Electrodiagnostic studies dated 06/01/95 to 04/20/05.
3. EEG dated 09/05/03.
4. Echocardiogram dated 09/08/03.
5. Carotid Doppler study dated 09/08/03.
6. Prior reviews dated 02/04/11 to 05/05/11.
7. Cover sheet and working documents to include letters from injured worker and physicians 05/19/11, 05/26/11
8. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):
The employee is a XX year old male who sustained an injury on XX/XX/XX. A clinical note dated 07/27/95 reported the employee had tremors of the hands. Physical examination reported no evidence of tremors. A clinical note dated 12/03/96 reported the employee was injured on XX/XX/XX secondary to lifting a 90 pound box. The note reported the employee underwent left shoulder surgery in January of 1995. The note reported the employee had reached MMI as of 08/10/96.

A clinical note dated 01/13/99 reported that the employee was injured on XX/XX/XX while climbing up a ladder at work when he noticed a sharp pain in the right shoulder and neck. The note reported the employee was status post right total shoulder joint arthroplasty on 07/19/97.

An EEG dated 09/05/03 reported normal findings.

A carotid Doppler study dated 09/08/03 put at minimal plaquing consistent with a stenosis of 1% – 15% in the right and left internal carotid arteries without evidence of significant flow limiting lesion.

A local note dated 10/02/03 reported the employee had complaints of left sided numbness and underwent extensive evaluation providing unrevealing findings, and the employee had no further episodes of this nature. The employee complained of some spasms of the left upper extremity.

An electrodiagnostic study dated 04/20/05 reported findings of mild right carpal tunnel syndrome and neuropathic lesion affecting the C7 and T8-T1 muscles of the left upper extremity.

A clinical note dated 11/17/10 reported the employee was wearing a left knee brace as he had fractured his patella and was being treated by an orthopedic surgeon. The employee continued to complain of shoulder pain with complaints that it felt like his shoulder was “popping out”. The employee was recommended to continue with Hydrocodone as needed for pain.

A Designated Doctor Evaluation dated 12/15/10 reported the employee did not require continued opiate therapy. The employee was to undergo weaning of Hydrocodone.

A clinical note dated 02/09/11 reported the employee said he was not taking as many Hydrocodone as in the past.

Clinical note dated 04/11/11 reported the employee complained of a little catching and popping of the left shoulder. The note reported the employee did not take any medications for pain. Physical examination reported 150 degrees of bilateral overhead elevation. Radiographs revealed that the employee’s bilateral prosthesis were in excellent position. The employee was recommended for stretching exercises.

A prior review dated 04/14/11 by Dr. reported the request for follow-up visit was non-certified. It appears that the request was denied secondary to a lack of a rational for a follow-up visit as a second opinion did not recommend surgical intervention.

A prior review dated 05/05/11 by Dr. reported the request for follow-up visit was non-certified. It appears the denial was based on recommendation for no surgical intervention by Dr..

A letter from the employee dated 05/19/11 reported the employee wished to see Dr. to guide him in keeping his shoulder functioning and that his prior Dr. was no longer seeing Worker’s Compensation patients.

A letter of medical necessity dated 05/26/11 from Dr. reported the employee would like to follow-up with Dr. on a quarterly basis to continue to follow his bilateral shoulder hemiarthroplasties.

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

The request for follow-up office visit with Dr. is not medically necessary. The employee had a history of bilateral shoulder hemiarthroplasties in 1997 and 2003. The employee was seen by Dr. for a second opinion on 04/11/11. Radiographs of the bilateral shoulders revealed excellent position of prosthesis. The employee was recommended for continued exercise. There is no additional documentation submitted for review to support the request for follow-up visit with orthopedic surgeon for evaluation of stretching exercises.

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

Official Disability Guidelines, Shoulder Chapter
Office visits
Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a “flag” to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of “virtual visits” compared with inpatient visits, however the value of patient/doctor interventions has not been questioned.