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Notice of Independent Review Decision

DATE OF REVIEW: 05/24/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Outpatient office visits Dates of Service 2/6/2011-2/06/2011 code 99213

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

Texas Board Certified Physical Medicine & Rehabilitation
Texas Board Certified Pain Management

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. Prior peer review by Dr. dated 11/12/09
2. Clinical notes by Dr. dated 12/17/09 to 02/06/11
3. Cover sheet and working documents.
4. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who sustained an injury on xx/xx/xx while putting a seatbelt on. The employee developed pain in the left low back, buttock and left lower extremity.

The employee is status post lumbar discectomy and fusion at L5 on 07/15/05. The employee has also undergone postoperative work conditioning and was provided a spinal cord stimulator in December of 2006.

The employee continued to have complaints of low back and left lower extremity pain through 2010.

The most recent clinical evaluation was on 02/06/11 by Dr.. The employee's symptoms were unchanged with the exception of pain being present in the right lower extremity instead of the left. The employee reported pain 6/10 on the visual analog scale that was improved with walking, stretching, use of a stimulator and medications. Physical examination at that visit revealed no significant findings but the examination was limited. The employee required no adjustments of her spinal cord stimulator.

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

The requested office outpatient visits is non-certified. The employee was seeing Dr. for pain management from December of 2009 through February of 2011. The February, 2011 clinical note indicated the employee was stated to be ill with pneumonia and was obtaining IG infusions at a cancer center. The employee did not require spinal cord stimulator adjustments. There was no discussion regarding further outpatient office visits in the clinical note. No further clinical notes were provided for review establishing the need for an outpatient office visit.

Without additional clinical documentation to establish the need for an outpatient office visit medical necessity is not established.

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

Official Disability Guidelines, Pain 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. ([Dixon, 2008](#)) ([Wallace, 2004](#)) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example [Chiropractic manipulation](#) and [Physical/Occupational therapy](#).