

SENT VIA EMAIL OR FAX ON
Oct/07/2011

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/07/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

One follow up visit (Anesthesiology) between 9-7-2011 and 11-6-2011

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

Anesthesiology

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have sustained work related injuries on xx/xx/xx. It is reported on the date of injury she slipped and fell over a pallet. Since that time she has been treated by numerous physicians, physiatrists, orthopedists. She continued to have generalized pain. She is reported to be despondent and depressed. She is reported to have previously undergone imaging studies which shows disc herniation at C5-6. MRI of lumbar spine is reported to show bilateral L5 neural foraminal narrowing as well as neural foraminal narrowing at L4. EMG/NCV study is reported to be consistent with cervical radiculopathy and lumbar studies are reported to be remarkable for L5-S1 radiculopathy. She has been treated with injections without sustained benefit. She was seen by Dr. on 04/29/10 for 2nd, 4th or 5th opinion. She has neck pain which is constant which radiates pain into her left arm and hand. She has similar pain in mid thoracic and lumbar spine radiating into left foot and leg. Current medications include weak narcotic analgesics, muscle relaxants and SSRI which have not

been beneficial. She has had left shoulder surgery without improvement. On physical examination she is noted to be depressed with constricted affect. She is 5'2" tall and weighs 203 lbs. She walks with a slow physiologic gait. She has reduced cervical range of motion. Trigger point and tenderness is noted in cervical, mid thoracic and lumbar regions. Marked decrease of neck range of motion, positive straight leg raise on left is reported. She has multiple areas of trigger point in mid thoracic and lumbar regions. She is opined to have chronic pain syndrome with cervical lumbar radiculopathy. She is recommended to have physical therapy, medication management, injection therapy. Records indicate the claimant continued to follow-up with Dr. She underwent a lumbar epidural steroid injection on 07/14/10. When seen in follow-up on 08/30/10 she is reported to have had 70% improvement with her lumbar epidural steroid injections. Dr. recommended additional injections which were apparently not approved on utilization review.

The most recent clinic note is dated 12/13/10 in which the claimant reports numbness and tingling down her foot and leg consistent with disease state. Her physical examination is grossly unchanged. She is recommended to undergo epidural steroid injections.

The record includes a EMG/NCV study of the upper extremities which reports electrodiagnostic evidence of cervical radiculopathy.

The initial request was reviewed by Dr. on 09/09/11. Dr. notes that the documentation submitted for review elaborates that the claimant complains of low back pain. He notes evidence based guidelines recommend office visit provide the patient meets specific criteria. Dr. notes that no documentation was submitted regarding the need for ongoing office visit. There is no recent documentation submitted for review regarding the claimant's significant clinical findings. He noted that given the lack of documentation, the claimant does not meet guideline recommendations and non-certified the request.

The appeal request was reviewed by Dr. on 09/19/11. Dr. non-certified the request. She noted there is no clear cut rationale establishing the need for follow-up visit from anesthesiologist. She noted no electrodiagnostic studies or imaging studies were submitted for review. She further reported RME dated 08/03/10 reported the claimant should be released from care. She opined medical necessity was not established and non-certified the request.

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

The request for follow-up visit with anesthesiology between 09/07/11 and 11/06/11 is not supported by the submitted clinical information. The available clinical records indicate the claimant has history of chronic neck and lumbar pain. The submitted clinical records indicate the claimant has not been seen by Dr. since 12/10. There are no recent clinical records providing appropriate information to establish the need for additional follow-up with pain management specialist / anesthesiologist. There are no clinical records for the last 10 months of treatment. Given the lack of supporting documentation establishing a medical need for continued follow-ups with anesthesiology, the request cannot be certified as medically necessary, and the prior utilization reviews are upheld.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES