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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: July/20/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Retrospective services 02/01/11 92214 (doctor's visit established patient moderate complexity)

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

MD, Board Certified in Anesthesiology and Pain Management

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

Health insurance claim forms, 2011
Request for reconsideration 04/05/11
Peer review 08/02/10
Progress notes 08/05/10 through 02/01/11 Dr.
Toxicology report, undated
Operative note lumbar transforaminal epidural steroid injection 07/15/10
11/11/09-2/2/10

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a female whose date of injury is xx/xx/xxxx. Records indicate she injured her low back as she was lifting boxes. The injured employee is noted to complain of low back pain with left leg pain. MRI of the lumbar spine performed 10/07/09 showed a 3mm left paracentral disc bulge at L2-3 that has significant left foraminal component severely narrowed. The injured employee underwent a left transforaminal epidural steroid injection on 07/15/10 L2 and L3, which was reported to provide 70% relief in left leg for six weeks then pain returned. Other treatment has included medications and physical therapy. A peer review dated 08/02/10 noted that the injured employee underwent designated doctor evaluation on 05/18/10 and it was recommended that the injured employee undergo MRI, EMG/NCS and FCE. The EMG/NCS performed on 05/21/10 was reported as normal. FCE was done on 06/02/10 and noted the injured employee was at light physical demand level while her job required heavy physical demand level. It was felt she was to be at maximum medical improvement from that date and given 5% impairment rating, and was returned to work with restrictions. The peer review physician opined that although the injured employee had been declared at maximum medical improvement with impairment rating, it appears she continued to have low back pain with some unknown etiology and medications may be required to help her deal with her pain. It was recommended that Neurontin was being tapered and there should be effort to decrease Lortab and substitute non-steroidal anti-inflammatories of some type. The peer reviewer further opined that medications were

indicated for her condition that were not related to the injury of 09/21/09. The injured employee has been followed by Dr. and was last seen on 02/01/11. Medications at that time were listed as Dulcolax; Aleve; Neurontin; Lortab; Tizanidine.

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

Although the injured employee has been determined to have reached maximum medical improvement per a designated doctor evaluation, she continues on prescription medications. This necessitates follow-up according to the ODG. The visit on 02/01/11 should be certified as medically necessary. The reviewer finds there is a medical necessity for retrospective services 02/01/11 92214 (doctor's visit established patient moderate complexity).

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

ACOEM-AMERICA 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)