

SENT VIA EMAIL OR FAX ON
Apr/01/2011

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Apr/01/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Repeat Diagnostic Interview x 1; Mental Health Testing x 2 hours

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified PMR 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
OD Guidelines

1. Cover sheet and working documents No Date
2. Peer review dated 07/21/10
3. Initial orthopedic consultation dated 09/08/09
4. Procedure note dated 11/24/09, 09/10/09, 07/31/09
5. Medical records Dr.
6. Medical records Dr.
7. Medical records Dr.
8. Operative report dated 02/24/10
9. Medical Records D.C.
10. MRI right shoulder dated 06/17/09
11. Designated doctor evaluation dated 09/03/09
12. Response to denial letter dated 02/16/11
13. Mental health evaluation treatment request
14. Letter dated 02/15/11
15. Utilization review determination dated 02/16/11, 03/04/11

16. Required medical examination dated 01/18/11
17. Functional capacity evaluation dated 09/04/09
18. Review of right shoulder MRI dated 01/06/11
19. Initial diagnostic screening dated 08/11/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was pulling down on a metal trailer door that got stuck and he had to jerk it down. He reports that he felt right shoulder pain. MRI of the right shoulder dated 06/17/09 revealed no rotator cuff tear or prominent tendinosis; borderline subacromial fat effacement; mild AC joint DJD, and no labral capsular abnormalities. The patient underwent right AC joint capsular injection on 07/31/09 and reported good relief.

Designated doctor evaluation dated 09/03/09 indicates that treatment to date includes PT and injection. Diagnoses are listed as right shoulder sprain, AC synovitis and myofascial pain. The patient was determined to have reached MMI as of 07/31/09 with 4% whole person impairment. Functional capacity evaluation dated 09/04/09 indicates required PDL is medium and current PDL is light. The patient underwent right AC joint capsular injection on 09/10/09 and reported good but temporary relief. The patient underwent right shoulder subacromial bursa injection on 11/24/09 with 80% pain relief.

The patient underwent right shoulder arthroscopy with subacromial decompression, acromioplasty and excision of right coracoacromial ligament on 02/24/10 followed by a course of postoperative physical therapy.

Extent of injury peer review dated 07/21/10 indicates that the compensable injury is a right shoulder sprain/strain and right shoulder impingement; left shoulder impingement is not a compensable injury. Initial diagnostic screening dated 08/11/10 indicates that BDI is 36 and BAI is 34. Diagnosis is major depressive disorder, single episode without psychotic features, severe.

Required medical examination dated 01/18/11 notes that diagnosis is resolved right shoulder sprain. There is no objective evidence that the claimant suffered significant damage or harm to the underlying structures of the body beyond a sprain injury. According to all objective data, there never was an impingement syndrome. The patient's complaint of a left shoulder injury has no credibility.

Initial request for repeat diagnostic interview x 1 and mental health testing x 2 hours was non-certified on 02/16/11 noting that there is no recent information available on the patient's status and it is unclear if he had work hardening. The patient was placed at MMI on 07/31/09. The denial was upheld on appeal dated 03/04/11 noting there is no basis to alter or amend the prior adverse determination.

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

Based on the clinical information provided, the request for repeat diagnostic interview x 1; mental health testing x 2 hours is not recommended as medically necessary, and the two previous denials are upheld. The patient underwent designated doctor evaluation and was determined to have reached maximum medical improvement as of 07/31/09 with 4% whole person impairment. Peer review dated 07/21/10 indicates that the compensable injury is a right shoulder sprain/strain and right shoulder impingement; left shoulder impingement is not a compensable injury. The patient underwent initial mental health evaluation on 08/11/10. There is then a gap in the treatment records until required medical examination dated 01/18/11. There is no comprehensive assessment of treatment completed in the interim or the patient's response thereto submitted for review. There is no indication that there has been a significant change in the patient's status to support repeat diagnostic interview and mental health testing.

RME notes that the extent of injury is resolved right shoulder sprain. Given the current clinical data, the request is not indicated as medically necessary and the two previous denials are upheld.

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)