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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Mar/11/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Consultation and Treatment for Depression

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

Board Certified Orthopedic Surgery

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 01/25/13, 02/12/13, 05/29/12, 12/13/11, 08/17/11

Copy of driver's license

Worker's compensation information sheet dated 08/09/11

Letter dated 02/20/13, 01/21/13, 02/05/13, 10/31/11, 07/31/12, 07/15/12, 06/13/12, 05/31/12,

05/04/11, 03/30/12, 02/16/12, 01/31/12, 11/30/11, 09/30/11

Lab report dated 09/23/11

Operative report dated 09/29/11

MRI of the cervical spine dated 01/08/13, 03/29/12

Office note dated 09/05/12, 08/01/12, 01/10/13, 01/11/13, 11/07/12, 07/31/12, 04/30/12,

06/27/12, 06/05/12, 05/22/12, 05/07/12, 05/10/12, 05/14/12, 05/15/12, 03/27/12, 02/10/12,

02/01/12, 01/18/12, 12/09/11, 07/19/11, 09/21/11, 09/09/11, 08/12/11, 07/19/11, 05/10/11,

05/24/11, 06/21/11, 11/04/11, 10/07/11, 09/30/11, 09/29/11, 09/26/11, 08/29/11

Patient message dated 02/19/13, 02/18/13, 02/01/13, 01/28/13, 01/25/13, 06/05/12, 05/22/12,

05/10/12, 08/29/11, 08/26/11, 08/16/11,

Radiographic report dated 09/06/11, 05/10/11, 08/30/11

Job summary dated 09/25/06

MRI left shoulder dated 09/06/11, 05/18/11

Physical therapy discharge summary dated 02/09/12

Handwritten note dated 04/04/12, 10/17/11, 06/13/11, 06/27/11

Procedure report dated 09/29/11

Handwritten physical therapy soap note dated 04/23/12, 02/03/12, 01/13/12, 01/06/12,

12/28/11, 12/13/11, 11/17/11, 11/11/11, 06/22/11, 06/20/11
Physical therapy reassessment dated 01/04/12, 12/02/11, 05/15/12
Peer/medical record review dated 05/03/12
EMG/NCV dated 07/12/12
Cervical myelogram dated 07/09/12
MRI cervical spine dated 08/16/12
Designated doctor evaluation dated 11/08/12, 07/19/12
Designated doctor medical record review dated 05/01/12, 07/22/11
CT cervical spine dated 07/09/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was working and felt a pop in his left shoulder. Treatment to date includes extensive diagnostic testing, left shoulder arthroscopic subacromial decompression on 09/29/11, physical therapy, injection therapy. Peer/medical record review dated 05/03/12 indicates that neither the mechanism of injury nor the MRI findings support an injury to the cervical spine. Overall, treatment to the left shoulder has been reasonable and necessary per ODG. The reviewer opines that at this time there is not much to offer the claimant other than maintenance care with office visits quarterly under the direction of one physician. The patient was determined to have reached maximum medical improvement. Designated doctor evaluation dated 07/19/12 indicates that the patient was given a release from his surgeon for full work on 02/17/12. He did not return to work due to continued shoulder and left neck symptoms. The sprains have not reached the point of MMI with expected MMI date of 10/01/12. Follow up note dated 01/11/13 indicates that the patient presents for recheck of neck pain. Note dated 01/10/13 indicates that the patient has not performed PT in the last 10 months. Medications are listed as Crestor, Trilipix, Omeprazole, Tramadol and Norco.

Initial request for consultation and treatment for depression was non-certified on 01/25/13 noting that ODG states that depression screening is recommended and recommends screening for psychiatric disorders for patients with chronic unexplained pain, delayed recovery, poor response to treatment. Comorbid psychiatric disorders commonly occur in chronic pain patients. In this case, however, there is indicates current documentation submitted for clinical review. The documentation that was submitted does not discuss any concerns regarding the claimant's mental health or comorbid psychiatric issues in conjunction with the chronic pain state. Without a clear clinical rationale for depression consultation and treatment, medical necessity of such is not established. The denial was upheld on appeal dated 02/12/13 noting that there are no complaints related to depression, anxiety or sleep disturbances noted in report of 09/12. Physical examination findings and complaints are no more recent than 09/12 and in the absence of significant factors identified on physical examination related to this request the medical necessity of a consultation and treatment for depression is not established.

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

The patient sustained injuries on xx/xx/xx and was subsequently treated with surgical intervention, physical therapy, injection therapy and medication management. Despite extensive records submitted for review, there is no mention of any significant psychological symptomatology. There is no indication that the patient presents with signs or symptoms of depression and/or anxiety. There is no indication that the patient presents with psychosocial factors that have impeded his progress with treatment completed to date. There is no clear rationale provided to support consultation and treatment for depression. As such, it is the opinion of the reviewer that the request for consultation and treatment for depression is not recommended as medically necessary.

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)