

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-0872-01
Name of Patient:	
Name of URA/Payer:	American Home Assurance
Name of Provider:	Texas Health
<small>(ER, Hospital, or Other Facility)</small>	
Name of Physician:	John Botefuhr, DC
<small>(Treating or Requesting)</small>	

March 30, 2006

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Health
John Botefuhr, DC
Division of Workers' Compensation

CLINICAL HISTORY

Available documentation received and included for review consists of initial and subsequent reports and treatment records from Drs. Upchurch et Botefuhr (DC); Dr. Banta (MD), Dr. Levy (MD), Dr. Willis (MD), Dr. Cunningham (MD), Dr. Banta (MD), Designated Dr. Leong (MD); peer review opinions for per-auth (Dr. Polsky, (MD) and position statement from attorney Fundis with Downs-Stanford, PC, MD). Diagnostic Reports: MRI and x-rays of right shoulder, electrodiagnostic reports.

Ms. _____, a 52-year-old right hand dominant female, injured her right shoulder while at work when a thick plastic door came off the machine and struck her on her right shoulder.

She consulted with Dr. Upchurch (DC). Diagnostic assessment included x-ray and MRI of the right shoulder, both negative aside from some subcoracoid bursitis. Electrodiagnostic evaluation (Don Dunlap, DO) on 1/12/05 impression was of a "right shoulder and right radicular injury at the C7-C8 dermatomes without findings of carpal tunnel syndrome". Nerve conduction studies performed on 4/11/05 (Jonathan Walker, M.D.) revealed electrophysiological manifestations found in the median motor/sensory abnormalities that could be suggestive of a compressive process demyelination process of the median nerve the wrists bilaterally. Treatment included manual therapy with adjunctive physiotherapeutic modalities.

The patient was referred for pain management purposes to Dr. Banta. He recommended trigger point injections on 1/26/05 after diagnosis of right cervical and shoulder sprain/strain.

Second opinion pain management consultation 3/30/05 Dr. Willis (MD) assessed right shoulder bursitis with myofascial pain syndrome and

recommended trigger point injections, physical therapy and pharmacological management.

A behavioral medicine consultation was performed on 4/5/05 (Pennick and Bohart, LPC). Discussed previous prescription for Zoloft by her family doctor three years previously, secondary to mild dysthymia, mood disturbance was not previously interfering with her occupational social functioning. Mental status exam was undertaken, revealing a GAF score 58, Beck depression/anxiety inventory revealing minimal depression and anxiety. Axis I diagnosis of adjustment disorder with depressed mood. Low level individual counseling was recommended.

FCE performed on 4/12/05 revealed a sedentary physical demand level. Patient was determined to be a good candidate for work hardening, referencing psychological overlay per Bohart (LPC) and history of anxiety/depression.

Second opinion orthopedic consultation 6/14/05 Dr. Cunningham (MD) documented ongoing problems with paresthesia and opined that diagnostic arthroscopy may be in order, following some good response to previous injections, a full rotator cuff strengthening program without significant help and lack of response to anti-inflammatories.

Second orthopedic opinion with Dr. Levy 7/8/05 FS rotator cuff syndrome, os acromiale, neurogenic pain. He performed the subacromial injection. Follow-up recommended arthroscopic surgery.

Designated doctor appointment (Dorothy Leong M.D) 8/8/05 opined that the patient had a positive impingement of the right shoulder and was not at MMI.

Arthroscopic glenohumeral debridement with radiofrequency rotator cuff repair and subacromial decompression/bursectomy was performed on 9/7/05 with Dr. Levy. This was followed up with physical therapy. Final follow-up recommended a modified return to work.

A second behavioral medicine (re) evaluation was undertaken on 12/1/05. Noted was an increased Zoloft dose post surgery secondary to increased depression symptoms. Beck anxiety/depression scale revealed worsened condition of moderate depression and minimal to

mild anxiety. Axis I diagnosis Major depressive disorder, single episode, moderate. Recommendation was for a multidisciplinary work conditioning program.

The carrier's attorney contends that services are unnecessary due to a prior prescription of the Zoloft, notations of historical depression, a lack of any self-report of depression to the designated doctor and a normal mental status reported by Dr. Levy, there was also some mix-up between preauthorization for work hardening versus work conditioning. Preauthorization request for psychotherapy and testing were denied based upon perceived non-qualification of the referring physician to evaluate depression and lack an evaluation by qualified mental health expert and a lack of use of adjunctive medication such as pain modulating anticonvulsives or topical anesthetics, as well as further investigation all the reason for continued pain from an orthopedic or rheumatological standpoint.

REQUESTED SERVICE(S)

Individual psychotherapy sessions one time per week for six weeks, biofeedback psychophysiological profile assessment with four modalities (EMG, PNG, TEMP and SC/GSR).

DECISION

Approve.

RATIONALE/BASIS FOR DECISION

The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

The records demonstrate that the patient has residual problems following surgery, including psychosocial issues which appeared to be a barrier to effective return to work. She has exhausted most forms of lower level interventions. The patient has acknowledged history of depression, which by all accounts seems to have worsened as a result of this injury requiring an increased dosage of Zoloft.

These are all factors that affect the duration of disability. Additionally, the Medical Disability Adviser acknowledges that comorbid conditions impacting recovery include the individual's ability to adhere to a rehabilitative exercise program.

Contrary to the carriers reviewers and attorneys position statement, I believe that the documentation clearly supports that the patient is an appropriate candidate for individual psychotherapy with biofeedback as requested. A qualified mental health provider assessed worsening depressive disturbances between two separate mental health evaluations spanning the treatment course, psychotropic medications had been attempted and in fact increased. Orthopedic /neurological/rheumatological ecological investigations had also been exhausted.

References:

The Work Loss Data Institute's *Official Disability Guidelines, third edition 2005*

The Medical Disability Adviser, fourth edition

The American College of Occupational and Environmental Medicines *Occupational Medicine Practice Guidelines,*

Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".

Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.

Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140

Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;

The American Physical Therapy Association *Guidelines for Programs for Injured Worker's*, 1995

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 31st day of March 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell