

MDR Tracking Number: M5-04-1312-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on January 13, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity is not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On the matters of medical necessity, the preparation of the patient's psychiatric status for date of service 01/29/03 **was found to be medically necessary**. The explanation of results of data to family, environmental intervention, and individual psychotherapy for dates of service 02/07/03 through 03/14/03 **was not found to be medically necessary**.

The respondent raised no other reasons for denying reimbursement for CPT Codes 90889, 90820, and 90822.

On April 7, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 97799-CP for dates of service 01/27/03 through 03/13/03 denied as "V". According to Commission Rule 133.301(a) an insurance carrier shall not retrospectively review those treatments/services for which preauthorization has been approved. The requestor obtain preauthorization for the Chronic Pain Management program, authorization number 450405-1645109. Therefore, reimbursement is recommended.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision is hereby issued this 9<sup>th</sup> day of October 2004.

Marguerite Foster  
Medical Dispute Resolution Officer  
Medical Review Division

MF/mf

**ORDER**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service **01/27/03 through 02/13/03** and **03/06/03 through 03/13/03** in this dispute.

This Order is hereby issued this 9<sup>th</sup> day of October, 2004

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/ms  
Enclosure: IRO Decision

## NOTICE OF INDEPENDENT REVIEW DECISION

March 30, 2004

Rosalinda Lopez  
Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Injured Worker:  
MDR Tracking #: M5-04-1312-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This patient sustained an injury on \_\_\_ when he was operating a heavy machine and two boxcars derailed and hit him. He reported pain in his neck and back, radiating down his legs. He saw a chiropractor for treatment and eventually entered into a chronic pain management program.

### Requested Service(s)

Preparation of patient's psychiatric status for others, explanation of results of data to family, environmental intervention, and individual psychotherapy from 01/29/03 through 03/14/03

### Decision

It is determined that the preparation of patient's psychiatric status with history and treatment for others on 01/29/03 was medically necessary to treat this patient's condition. However, the explanation of results of data to family, environmental intervention, and individual psychotherapy from 02/07/03 through 03/14/03 were not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

The patient sustained an injury on \_\_\_ and was examined by a designated doctor who felt that the patient would not reach Maximum Medical Improvement (MMI) until on/about 01/06/03. This patient was not a surgical candidate. It does appear that there were psychosocial deficits that would have benefited from the implementation of upper level therapeutics like a chronic pain management program. However, the provider's duration of care is atypical and is not supported in the reviewed medical records. Therefore, it is determined that the preparation of patient's psychiatric status with history and treatment for others on 01/29/03 was medically necessary. However, the explanation of results of data to family, environmental intervention, and individual psychotherapy from 02/07/03 through 03/14/03 were not medically necessary.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- *Clinical practice guidelines for chronic, non-malignant pain syndrome patients II: An evidence-based approach.* J Back Musculoskeletal Rehabil 1999 Jan 1;13;47-58.
- *Overview of implementation of outcome assessment case management in the clinical practice.* Washington State Chiropractic Association; 2001. 54p.
- Robbins H, et al. *A prospective one-year outcome study of interdisciplinary chronic pain management: compromising its efficacy by managed care policies,* Anesth Analg. 2003 Jul;97(1):156-62.
- *Unremitting low back pain. In: North American Spine Society phase III clinical guidelines for multidisciplinary spine care specialists.* North American Spine Society. Unremitting low back pain. North American Spine Society (NASS); 2000. 96p.

Sincerely,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:vn