

MDR Tracking Number: M5-05-1340-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 1-10-05.

The IRO reviewed office visits, psychiatric diagnostic interview, and preparation of report.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO Decision.

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 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- 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 8-3-04 through 9-20-04 as outlined above in this dispute.

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 Order is hereby issued this 10th day of March 2005.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS
[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 3/8/05

TWCC Case Number:	
MDR Tracking Number:	M5-05-1340-01
Name of Patient:	
Name of URA/Payer:	Southwest Center Medical
Name of Provider: (ER, Hospital, or Other Facility)	Southwest Center Medical
Name of Physician: (Treating or Requesting)	Nicholas Padron, MD

February 23, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in psychiatry. 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 Texas Workers' Compensation Commission 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 Workers Compensation Commission

CLINICAL HISTORY

This patient sustained a thoracic and lumbar injury on ____ after falling off a ladder onto her left buttock and left side. Patient was working as a prep cook at _____ and had been employed for 14 years. Patient was diagnosed with thoracic sprain and lumbar sprain. MRI was normal.

After initial rehabilitation efforts, including physical therapy 3 times a week, patient requested a change in treating physicians to Wol+Med Back and Neck Pain Center. Patient had a Functional Capacity Evaluation and was referred to pain management program.

Her initial diagnostic screening included a psychological and behavioral assessment. It was felt that patient did not have conversion disorder, factitious disorder, or malingering but did have symptoms of

depression and anxiety which appeared related to the accident. There is no evidence of prior psychiatric history. Patient was referred to the Inter-Disciplinary Rehabilitation Program/Pain Management Program.

REQUESTED SERVICE(S)

Office visit (99203), Office Visit-Level III (99213), Psychiatric Diagnostic Interview Examination (90801), Preparation of Report of Patient's Psychiatric Status, History, Treatment, or Progress (90889) for dates of service 8/3/04 through 10/5/04.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

Upon completion of the pain management program, patient was returned to work full time without restrictions. Patient was given an impairment rating of 5% and discharged.

This patient has completed successful treatment and has returned to work on a full time basis. The assessment and treatment planning for this patient by Wol+Med was well within the standards of medical practice.