

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address Texas Health 5445 La Sierra Dr. #204 Dallas, Texas 75231	MDR Tracking No.: M5-05-1976-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Casualty Company of R, Box 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
12-18-03	12-18-03	CPT code 90801	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues.

Regarding CPT code 90801 – Per Ingenix EncoderPro, this is not a timed code. The descriptor states “Psychiatric diagnostic interview examination”. Per Rule 134.202(b) and (c)(1), the MAR is \$190.88. The requestor is asking for \$1800.00. Recommend reimbursement of \$190.88.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$650.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services in dispute (\$190.88) consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Ordered by:

6-24-05

Authorized Signature

Typed Name

Date of Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

NOTICE OF INDEPENDENT REVIEW DECISION

June 22, 2005

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 #: M5-05-1976-01
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 §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 TMF physician reviewer who is board certified in Psychiatry which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 2003. The TMF physician reviewer 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 24 year-old female injured her right wrist on ___ while trying to break her fall while retrieving a brake drum from a bin. She has been treated with therapy and work hardening rehabilitation.

Requested Service(s)

Psychiatric diagnostic interview examination for date of service 12/18/03

Decision

It is determined that there is medical necessity for the psychiatric diagnostic interview examination for date of service 12/18/03 to treat this patient's medical condition.

Rationale/Basis for Decision

This patient has received differing medical opinions regarding her medical disability. She received different forms therapy and medications and did not respond. She continued to complain of pain. The consultation for a behavioral medicine interview was medically necessary to understand the underlying psychopathology that interfered with her recovery. Without this consultation, this patient was at a higher risk of becoming more confused, depressed and at a higher level of anxiety that could potentially result in a treatment resistant condition. Therefore, the psychiatric diagnostic interview examination for date of service 12/18/03 was medically necessary to treat this patient's medical condition.

Sincerely,

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

GBS:dm

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M5-05-1976-01

Information Submitted by Requestor:

- Progress Notes

Information Submitted by Respondent:

- Progress Notes
- Functional capacity evaluation
- Impairment Rating
- Claims