



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestor=s Name and Address:

Texas Health
5445 La Sierra Dr. #204
Dallas, Texas 75231

MDR Tracking No.: M5-06-2077-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Zurich American Insurance Company, Box 19

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "The claim was denied as 'unnecessary medical treatment per peer review.' We did not receive a copy of the peer review... It is our position that Zurich Insurance has established an unfair and unreasonable time frame in paying for the services that were authorized and rendered to..."

Principle Documentation:

- 1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "...The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. The carrier asserts that it has paid according to applicable fee guidelines..."

Principle Documentation:

- 1. DWC-60/Table of Disputed Service

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Table with 4 columns: Date(s) of Service, CPT Code(s) or Description, Medically Necessary?, Additional Amount Due (if any). Row 1: 9-23-05, 90801, [X] Yes [] No, \$196.40. Row 2: Total Due, \$196.40.

PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical

Dispute Resolution 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 did prevail on the disputed medical necessity issues. Per Rule 134.202(a)(1) the amount due the Requestor for the items denied for medical necessity is \$196.40. Per the 2002 MFG CPT code 90801 this is not a timed code. The descriptor states "Psychiatric diagnostic interview examination". Per Rule 134.202(b) and (c)(1), the Mar is \$196.40. Recommend reimbursement of \$196.40.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1, 134.202
Texas Labor Code Sec. § 413.011(a-d), 413.031

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the carrier must refund the amount of the IRO fee (\$460.00) to the Requestor within 30 days of receipt of this order. The Division has determined that the Requestor is entitled to additional reimbursement in the amount of \$196.40. The Division hereby **ORDERS** the Respondent to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision and Order by:

	Medical Dispute Officer	10-24-06
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. 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. The Division is not considered a party to the appeal.

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

October 2, 2006

TX DEPT OF INS DIV OF WC
AUSTIN, TX 78744-1609

CLAIMANT: ___

EMPLOYEE: ___

POLICY: M5-06-2077-01

CLIENT TRACKING NUMBER: M5-06-2077-01/5278

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above mentioned case to MRIOA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing between that 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.

Records Received:

Records received from the state:

Notification of IRO Assignment - 8 pages

Records received from the requestor:

Initial Behavior Medicine Consult including addendum, Tracey Duran, MS, LPC, LMFT 9/23/05 - 7 pages

Letter of Medical Necessity, Bradley J. Eames, DO 9/11/06 - 2 pages

Records received from respondent:

Table of Disputed Services - 1 page

Peer Review 7/25/05 - 5 pages

Letter to DWC from Gilbert Mayorga, MD 3/21/06 - 1 page

Letter to patient from DWC 3/30/06 - 1 page

Peer Review 4/17/06 - 6 pages

Peer Review Addendum 4/30/06 - 5 pages

Letter to DWC from Flahive, Ogden, & Latson 8/29/06 - 2 pages

Letter to MRIOA from Flahive, Ogden, & Latson 9/28/06 - 2 pages

Summary of Treatment/Case History:

The claimant is a 35-year-old Hispanic female who was injured on ___, while working as an accountant for _____. She sustained injuries to her neck and back. Subsequent x-rays and MRI showed disc protrusion at cervical and lumbar vertebrae. An EMG of the cervical spine suggested radiculopathy. The patient has gone through medication treatment, massage, and aquatics. She reported that her pain averaged 7/10 on a daily basis. Her chronic pain has interfered with her recreational, social, and familial activities. She has difficulty with acts of daily living, such as grooming, doing household chores, bending, sitting, standing, walking, etc. Her employment with the company has been terminated. She feels less confident in herself and feels useless, helpless, and like a burden. She is also suffering from anxiety,

insomnia and depression. The patient reported no record of mental disorder impacting her independent functioning, prior to the injury.

Questions for Review:

Please evaluate the medical necessity for psychiatric diagnostic interview (#90801).

Explanation of Findings:

Please evaluate the medical necessity for psychiatric diagnostic interview (#90801).

Yes, a psychiatric diagnostic interview was medically necessary.

The patient did not have any pre-existing mental disorder. Her psychological distress appears to be a direct result of compensable injury. An initial psychiatric diagnostic interview was necessary to assess any psychiatric condition and to formulate a comprehensive treatment plan, which is needed in order to determine how to get an injured worker back to work in a timely manner.

Conclusion/Decision to Certify:

Psychiatric diagnostic interview was medically necessary.

Applicable Clinical or Scientific Criteria or Guidelines Applied in Arriving at Decision:

General Standards of Psychiatric Practice
Evidence Based Medical Practice

References Used in Support of Decision:

ACOEM Guidelines – pg. 87, 91, 106, 109, 114, 398–403

TWCC Mental Health Treatment Guidelines, Section 3 (A and B) – Criteria for Referral to Chronic Pain Program, and Section H–Ongoing treatment Recommendations.

American Academy of Pain Management Guidelines

Gatchel, Robert J. Clinical Essentials of Pain Management 2005, American Psychological Association
Turk, D.C & Gatchel R.J. (eds.). Psychological Approaches to Pain Management: a Practitioners Handbook, Second Edition. New York: Guilford Press.

American Psychiatric Association Practice Guidelines

The physician who provided this review is a diplomate of the American Board of Psychiatry and Neurology in Psychiatry and Adolescent Psychiatry. This reviewer is a member of the American Psychiatric Association, the American Society of Clinical Psychopharmacology and the American Society of Addiction Medicine. This reviewer has been in active practice since 1997.

MRloA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, and the DWC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRloA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRloA represent the opinions of the physician reviewers and clinical

advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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Case Analyst: Lori B ext 569