

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-4337.M5

MDR Tracking Number: M5-03-2639-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 06-18-03.

The IRO psychiatric diagnostic evaluation and biofeedback rendered 10-14-02 and 10-31-02 that was denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for psychiatric diagnostic evaluation. Consequently, the requestor is not owed a refund of the paid IRO fee.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for biofeedback. 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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was 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 10-13-03, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
10-31-02	90830	\$375.00		V	\$125.00 (3 units)	Rule 134.600 (h)(4) and 134.600 (b)(1)(B)	Services were preauthorized by carrier authorization# 021002-015. In accordance with 134.600 (h)(4) Recommended reimbursement \$375.00
TOTAL		\$375.00					The requestor is entitled to reimbursement of \$ 375.00

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 Decision is applicable for date of service 10-31-02 in this dispute.

This Decision is hereby issued this 9th day of February 2004.

Georgina Rodriguez
 Medical Dispute Resolution Officer
 Medical Review Division

January 15, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
 Corrected Letter C**

RE: MDR Tracking #: M5-03-2639-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in psychiatry. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 45 year-old male who sustained a work related injury on ___. The patient reported that while at work he fell off a pair of stilts injuring his cervical, thoracic and lumbar spine. The diagnoses for this patient included cervicobrachial syndrome, thoracic strain and lumbar strain. The patient was treated with electrical muscle stimulation, hot/cold packs, intersegmental traction and manipulation, a work hardening program, lumbar epidural steroid injections, oral medications and sacroiliac joint arthrogram and anesthetic. The patient has also undergone back surgery. The patient underwent a cervical MRI on 5/13/97, a thoracic spine MRI on 12/16/97, a cervical spine MRI on 12/29/99, a lumbar spine MRI on 10/18/00 and an EMG. The patient was referred for a psychophysiological profile assessment on 10/31/02.

Requested Services

Psychiatric evaluation on 10/14/02 and biofeedback on 10/31/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 45 year-old male who sustained a work related injury on ___. The ___ physician reviewer indicated that the patient has gone on to develop a chronic pain syndrome partially related to his spinal injuries and co-morbid degenerative disc disease throughout his spine. The ___ physician reviewer also indicated that the patient's significant disc protrusion led to a lumbar laminectomy and subsequent fusion to stabilize the laminectomy sites. The ___ physician reviewer explained that the patient achieved maximum benefit of all treatment modalities including multiple pain injections, surgery, chiropractic care and ongoing pain management. The ___ physician reviewer noted that the patient remained in chronic pain. The ___ physician reviewer also noted that the patient had undergone a psychiatric evaluation and biofeedback on 10/14/02 and 10/31/02. The ___ physician reviewer explained that a psychiatric evaluation and psychological testing can help to determine the degree of emotional factors that were significant contributors to this patient's ongoing pain. However, the ___ physician reviewer also explained that the documentation provided did not show that a psychopharmacologic assessment was performed. The ___ physician reviewer further explained that the documentation provided failed to show that the evaluation on 10/14/02 yielded any treatment suggestions or new data. Therefore, the ___ physician consultant concluded that the biofeedback on 10/31/02 was medically necessary to

treat this patient's condition. However, the ___ physician consultant also concluded that the psychiatric evaluation on 10/14/02 was not medically necessary to treat this patient's condition.

Sincerely,

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