



Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Alfonso Ochoa, M.D. 909 S. Airport Dr Weslaco, TX 78596	MDR Tracking No.: M5-06-0358-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: TX Workers Compensation Sol, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 form, Explanations of Benefits and CMS 1500's.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response received.

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-3-04 – 3-30-05	CPT codes 97124, 97032, 98940, 99213, 99080-73, 97110, 97116, 97140, G0283	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,588.31

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. The amount due the requestor for the items denied for medical necessity is \$2,588.31.

Based on review of the disputed issues within the request, the 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 Medical Dispute Resolution.

CPT code 99455 on 1-17-05 was denied by the carrier as "V-unnecessary treatment with peer review." According to Rule 134.202 this disability exam is a required report. Per Rule 134.202 (6)(F) the treating doctor shall bill the medical disability examination with modifier "VR" to indicate a review of the report only, and shall be reimbursed \$50.00. The insurance company will be billed for not adhering to this rule.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202(c)(1) and 134.202 (6)(F).

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 (\$650.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to reimbursement in the amount of \$2,638.31. The Division hereby **ORDERS** the insurance carrier 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:

Donna Auby

12-21-05

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.

December 16, 2005

TDI, Division of Workers' Compensation
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-06-0358-01
DWC#:
Injured Employee: ____
DOI: ____
IRO Certificate No.: IRO 5055

Dear Ms. ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Pain Management and Physical Medicine and Rehab, and is currently on the DWC Approved Doctor List.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,

Gilbert Prud'homme
General Counsel
GP:dd

REVIEWER'S REPORT

M5-06-0358-01

Information Provided for Review:

DWC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Office Notes 12/03/04 – 03/30/05

FCE 02/02/05

EMG 12/16/04

Radiology 12/03/04

Information provided by Respondent:

Designated Reviews

Orthopedics:

Office Notes 12/28/04 – 03/15/05

Pain Management:

Office Visit 12/29/04

Clinical History:

The claimant sustained a low back injury while at work on _____. It was reported that she was putting a pan down when she felt low back pain. She underwent conservative therapy and was able to return to regular duty on 11/01/04 but had her pain exacerbated about 2 weeks after that.

Disputed Services:

Massage, electrical stimulation, chiropractic manipulation, office visits, required reports, therapeutic exercises, gait training, manual therapy techniques, and electrical stimulation from 12/03/04 through 03/30/05.

Decision:

The reviewer disagrees with the determination made by the insurance carrier and is of the opinion the services in dispute as stated above were necessary in this case.

Rationale:

This patient originally reported symptoms consistent with a right L5 radiculopathy. Although her symptoms reduced adequately during conservative therapy to allow her to return to work, she was unable to continue this effort because of recurrence of symptoms. Subsequent investigations had diagnostic evidence consistent with right L5 radiculopathy, and the care rendered was reasonable given this diagnosis.