MDR Tracking Number: M5-03-2611-01

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 6-6-03.

The IRO reviewed consultation, prolonged consultation, electromyography, somatosensory testing, NCV testing, H/F reflex studies, muscle testing, and conductive needles rendered on 10-10-02.

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 $460.00** 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.

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 9-3-03, 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
10/10/02	95925 93740 95851 left 95851 right	175.00 84.00 36.00 36.00	0.00	D R F F	175.00 one or more nerves 84.00 36.00 ea extremity	96 MFG Med GR and CPT descriptors and Rule 133.307 (g) (3)	TWCC records indicate no TWCC-21 on file; therefore, review of code 93740 will be per the MFG. Relevant documentation was not submitted to support delivery of these services. No reimbursement recommended.
TOTAL		331.00					The requestor is not entitled to reimbursement.

The above Findings and Decision are hereby issued this 20th day of January 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

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 10-10-02 in this dispute.

This Order is hereby issued this 20th day of January 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

August 27, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking # M5-03-2611-01
IRO Certificate # IRO 4326

___ 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 ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional 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 ___ 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 patient sustained a lower back injury on ___ while lifting boxes. He was treated by a physician from the date of injury through 07/25/02 for a diagnosis of lumbar sprain/strain with physical therapy and manipulation. The patient was placed at maximum medical improvement on 07/25/02 with a 0% impairment rating. The patient later started seeing a chiropractor on 09/05/02.

Requested Service(s)
Consultation, prolonged consultation, electromyography, somatosensory testing, diagnostic nerve conduction velocity testing, H or F reflex studies, muscle testing, and conductive needles from 10/10/02

Decision
It is determined that the consultation, prolonged consultation, electromyography, somatosensory testing, diagnostic nerve conduction velocity testing, H or F reflex studies, muscle testing, and conductive needles from 10/10/02 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision
On 10/10/02, it was recorded and documented that the patient had subjective symptoms that would appear appropriate for this study. In addition, the patient had verified MRI changes.

Given the nature of the patient's findings on the MRI coupled with the objective examination performed on 10/10/02, the rationale is clear. During this examination, the physician recorded muscle weakness in a specific muscle (extensor HL) and positive orthopedic testing as well as sensory changes to pinprick. These specific objective findings, coupled with the subjective symptoms of three months of low back pain with radiation into the buttocks and/or lower extremity, along with the positive findings reported by MRI, develop the rationale and appropriateness for the procedure in question.

The request for this procedure, given the above consideration, is consistent with standards of practice within the chiropractic profession as well as the general medical community and consistent with generally accepted standards of care. Therefore, it is determined that the consultation, prolonged consultation, electromyography, somatosensory testing, diagnostic nerve conduction velocity testing, H or F reflex studies, muscle testing, and conductive needles from 10/10/02 were medically necessary.

Sincerely,