

MDR Tracking Number: M5-02-02151-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the NCV study and CPT test performed and billed on 04-26-01 and 5-10-01 were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that the medical necessity fees were the only fees involved in the medical dispute to be resolved. As the NCV study and CPT test were not found to be medically necessary, reimbursement for dates of service from 04-26-01 through 5-10-01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 28th day of May 2002.

Dee Z. Torres, Medical Dispute Resolution Officer  
Medical Review Division

DZT/dzt

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and subsequently re-delegated by Virginia May, Deputy Executive Director.

Enclosure: IRO decision

May 2, 2002

Texas Workers' Compensation Commission  
Medical Dispute Resolution  
4000 South IH-35, MS 48  
Austin, TX 78704-7491

Attention: Dee Torres

**REVISED**

Re: Medical Dispute Resolution  
MDR #: M5-02-2151-01  
IRO Certificate No.: I RO 5055

Dear Ms. Torres:

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

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a Doctor of Chiropractic Medicine.

**THE REVIEWER OF THIS CASE AGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.**

I am the Secretary and General Counsel of \_\_\_ 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 any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

Secretary & General Counsel

**MEDICAL CASE REVIEW**

This is for \_\_\_\_. I have reviewed the medical information forwarded to me concerning TWCC Case #M5-02-2151-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. TWCC IRO Assignment, dated 03/26/02, 2 pages.
2. TWCC #60, Medical Dispute Resolution Request/Response, dated 02/21/02, 3 pages.
3. TWCC #60, Table of Disputed Services from 04/26/01 to 05/10/01, one page.
4. Explanation of Benefits for date 05/10/01, one page.
5. HCFA-1500, Claim Form/TWCC-67, for date of service 05/10/01.
6. Letter of response to IRO from \_\_\_\_, dated 04/02/02, 3 pages.
7. \_\_\_\_ response for reconsideration, letter dated 02/12/02, one page.
8. Office visit reports from \_\_\_\_ from 03/02/01 to 10/12/01, 12 pages.
9. Doctors \_\_\_\_ operative report, dated 08/31/00, 3 pages.
10. \_\_\_\_ operative report, dated 03/09/01, 2 pages.
11. \_\_\_\_ anesthesia report, dated 03/09/01, one page.
12. \_\_\_\_, dated 03/16/01, one page.
13. \_\_\_\_, second surgical opinion, dated 08/24/01, one page.

14. \_\_\_ operative report, dated 03/12/02, 5 pages.
15. \_\_\_ report, dated 03/12/02, 4 pages.
16. \_\_\_, summary reports, 2 pages.
17. \_\_\_, request and reconsideration forms, dated 02/05/02 and 04/20/02, 2 pages.
18. \_\_\_, lumbar spine report, dated 01/19/01, one page.
19. \_\_\_, lumbar spine report, dated 03/02/01, one page.
20. \_\_\_, MRI of the lumbar spine w/wo gadolinium, dated 03/28/01, one page.
21. \_\_\_, MRI reports of the left knee and MRI reports of the right knee, dated 04/16/01, 2 pages.
22. \_\_\_, lumbar spine x-ray report, lumbar myelogram report, and CT myelogram report, dated 04/11/01, 7 pages.
  
23. Sensory nerve study, lower extremity, dated 02/01/01, 2 pages.
24. NCV, lower extremity, dated 02/15/01, one page.
25. PAR Neurological, NCV upper extremity report, EMG upper extremity report, dated 04/10/01, one page.
26. Nerve conduction velocity report, dated 04/26/01, 2 pages.
27. Sensory nerve conduction threshold (CPT), dated 05/10/01, 3 pages.
28. \_\_\_, information concerning the neurometer CPT nerve conduction threshold (SNCT), dated 06/28/01, 6 pages.

B. SUMMARY OF EVENTS:

Apparently, two nerve conduction studies were performed, and there is a discrepancy concerning payment and billing of these examinations.

C. OPINION:

I AGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.

The following opinion is directed only for billing of NCV, 95900WP, on 04/26/01, and current perception threshold test (CPT), 95904WP, on 05/10/01.

The documentation reviewed does not appear to support the definition of the billed procedures and/or lacks documentation to support medical necessity to justify the procedures.

Request for reconsideration form mentions, "This test was requested by surgeon before surgery." Documentation was not found to support this statement.

D. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

---

Date: 30 April 2002