

MDR Tracking Number: M5-04-1715-01

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 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 2-12-04.

I. DISPUTE

Whether there should be reimbursement for 95831, 95851, 95925, 95999, 95900, 95904, 95935 and 97750.

II. FINDINGS

1. The insurance carrier submitted an untimely response to the request for medical dispute resolution.
2. On 5-3-04, 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.

III. RATIONALE

- a. 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.

- b. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
2-24-03	95831	\$50.00	\$0.00	G	\$29.00	CPT Code Descriptor	Manual muscle testing is not global to range of motion test performed on this date, MAR reimbursement of \$29.00 is recommended.

2-24-03	95851	\$50.00	\$00.00	G	\$36.00	CPT Code Descriptor	Range of Motion test is not global to manual muscle test performed on this date, MAR reimbursement of \$36.00 is recommended.
3-5-03	95925	\$175.00	\$122.50	F	\$175.00	CPT Code Descriptor Preamble	MAR reimbursement is recommended, therefore, the requestor is entitled to additional reimbursement of \$52.50.
3-5-03	95935 (4)	\$212.00	\$148.40	F	\$53.00 / study per extremity	CPT Code Descriptor	Report indicates radiating pain in both lower extremities. H and F wave studies were performed bilaterally to lower extremities. The appropriate reimbursement is \$212.00 per MFG. Therefore, the difference between amount paid and MAR = \$63.60.
10-17-03	97750 (2)	\$140.00	\$35.26	F	\$35.26 per unit	CPT Code Descriptor	MAR reimbursement results in additional reimbursement of \$35.26 is recommended.
TOTAL							The requestor is entitled to reimbursement of \$216.36 .

IV. DECISION & 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 dates of service 2-24-03 through 10-30-03 in this dispute.

The above Findings, Decision and Order are hereby issued this 29th day of September 2004.

Elizabeth Pickle
 Medical Dispute Resolution Officer
 Medical Review Division

April 28, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Corrected dates of service in Rationale.

Re: Medical Dispute Resolution
MDR #: M5-04-1715-01
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

___ 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.

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.

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 Chiropractic Medicine who is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

Correspondence
H&P and office notes
Muscle testing and range of motion reports
Operative and Radiology reports

Clinical History:

The records indicate the patient injured his low back, right wrist and hand on the job on _____. An examination was performed and appropriate treatment begun. Over the course of time, conservative care was attempted. Over the course of treatment, referrals were made as well as appropriate diagnostic testing, which confirmed the patient's diagnosis and extent of injury. Over the course of time, intensive conservative care was attempted. Due to ongoing problems, lumbar ESIs were necessary, and the patient

eventually underwent lumbar spine surgery. Due to the nature and extent of this patient's injuries, the treating doctor ordered additional diagnostic testing

Disputed Services:

The following treatment and services during the period of 02/24/03 through 10/30/03:

- Unlisted neurological/neuromuscular diagnostic procedure-technical component
- Nerve conduction study-technical component
- Muscle testing
- Range of motion measurements

Decision:

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

Rationale:

Due to the nature and extent of this patient's injuries, and due to his lack of response, additional diagnostic testing was necessary to specifically isolate and confirm this patient's injuries, as well as to assist and formulate an appropriate treatment plan.

There is sufficient documentation on each diagnostic procedure, and all denied services fall within National Accepted Treatment Guidelines for this type of injury. Each specific denied service provided appropriate diagnostic information to the treating doctor, which assisted him in the treatment of this patient's on the job injury. In conclusion, it was, in fact, reasonable, usual, customary, and medically necessary for this patient to receive the unlisted neurological/neuromuscular diagnostic procedure-technical component, nerve conduction/motor study-technical component, nerve conduction/sensory study-technical component, muscle testing and range of motion during the period of 02/24/03 through 10/30/03.

Sincerely,