

MDR Tracking Number: M5-04-2594-01

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 4-20-04.

The IRO reviewed somatosensory testing, electromyography, nerve conduction and sense nerve conduction rendered on 8-21-03 denied based upon "U".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

The IRO concluded that 95925 and 95904 testing were not medically necessary. The IRO concluded that 95864 Needle EMG and 95903 Motor H/F waves were medically necessary. Regarding 95900 the reviewer found 8 of 18 studies were medically necessary.

On this basis, the total amount recommended for reimbursement (Total recommended for 95864, 95903 and 8-95900 = \$1092.88 minus amt. paid for 95900 of \$171.24 = \$ 921.64) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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

On 7-23-04, 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.

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

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
8-21-03	95934 (2)	\$106.00	\$89.40	F	\$44.70 X 2 = \$89.40	MAR	Paid in accordance with Rule 134.202, no additional reimbursement is recommended.

This Decision is hereby issued this 4th day of October 2004

Elizabeth Pickle
 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 (\$921.64) 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 8-28-01 through 12-28-01 in this dispute.

This Order is hereby issued this 4th day of October 2004

Elizabeth Pickle
 Medical Dispute Resolution Officer
 Medical Review Division

June 28, 2004

David Martinez
 TWCC Medical Dispute Resolution
 4000 IH 35 South, MS 48
 Austin, TX 78704

Patient:
 TWCC #:
 MDR Tracking #: M5-04-2594-01
 IRO #: 5251

Ziroc has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Ziroc for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Ziroc has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Neurology. The reviewer is on the TWCC Approved Doctor List (ADL). The Ziroc health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Ziroc for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

There is a neurosurgical consultation from Dr. D dated December 16, 2003. He stated that the patient had low back pain and pain radiating into the left lower extremity for six months. He was injured at work while working for a drilling company. He was lifting a heavy pipe, bent over and strained himself. There was no bowel or bladder dysfunction. He had been to physical therapy and had two epidural steroid injections. His examination at that time showed weakness of the left anterior tibial muscle and normal reflexes. There was no clonus and strain leg raising was positive on the left side. An MRI and CT study included the right saphenous, superficial peroneal, deep peroneal, lateral dorsal cutaneous, medial calcaneal, and left medial calcaneal, radial sensory, dorsal cutaneous, musculocutaneous, antibrachial cutaneous, median third digit sensory nerve, ulnar fifth digit sensory nerve and left sural, saphenous, superficial peroneal, and deep peroneal. There were four F-waves done that included bilateral median bilateral posterior tibial and also two H-reflexes, which were both left and right posterior tibial nerves. There were somatosensory potentials that included C-6 bilaterally, C-7 bilaterally, C-8 bilaterally, L-4 bilaterally, S-1 bilaterally, posterior tibial bilaterally and bilateral median somatosensory potentials.

DISPUTED SERVICES

Under dispute is the medical necessity of somatosensory testing, electromyography, nerve conduction and sense nerve conduction.

DECISION

The reviewer disagrees with the prior adverse determination regarding 95864 Needle EMG and 95903 Motor H/F waves.

The reviewer agrees with the prior adverse determination regarding 95925 Somatosensory testing and 95904 Sensory testing.

Regarding 95900 nerve conduction velocity and/or latency studies, the reviewer has found medical necessity for 8 of the 18 studies performed. Those studies determined to be medically necessary and appropriate included tests of the bilateral median, ulnar, tibial and peroneal nerves. Other 95900 studies performed were not found to be medically necessary.

BASIS FOR THE DECISION

Upon review of the medical records provided for this patient, the main concern was that this patient had a lumbar radiculopathy, likely present on the right, but some symptoms suggested that there may be some improvement on the left. The history does not reflect much going on in the upper extremities, but one physician had ordered an MRI of the neck, and there were also comments of numbness in the hands. So, clinically, there was some concern that the patient may have also injured his neck and might possibly be having some cervical radiculopathy. There were no comments made as to whether this patient had carpal tunnel entrapment, or any other abnormalities. Certainly, based on the entire review of the medical records, there was no evidence that this patient was suffering from a peripheral neuropathy.

Nerve conductions and electromyography testing are tests that are performed by trained physicians, but technicians are allowed to do motor and sensory nerve conductions, as well as somatosensory evoked potentials, if properly trained. One nice thing about the EMG study is that you tailor the test to the clinical diagnosis and to the patient's complaint. The EMG test is not like an electrocardiogram where you do the same electrocardiogram on every patient, but each test must be tailored for each patient's complaint. There are accepted standards of testing that should be done based on clinical history and examination. The testing that was done by Mobile Diagnostics of Texas basically studied almost every nerve that could possibly be studied in the human body. This is certainly not the standard of electromyography.

The reviewer finds that the following nerves were within the standard for the patient's complaints: the bilateral median and bilateral ulnar, and in the lower extremities, bilateral posterior tibial and peroneal nerves were reasonable.

The F-wave testing that was done, which included bilateral median, bilateral posterior tibial and the H-reflexes was reasonable in this case.

The EMG needle examination testing was done in all four extremities, yet granted, only one unit was charged. This was a reasonable charge in this case, as unnecessary testing was not actually billed.

There are numerous nerves in motor and sensory that provide no information and are unnecessary in the standard of EMG in this particular study. These nerves include the right radial, right musculocutaneous, the right axillary, the left radial, the left musculocutaneous, left axillary, left medial and lateral plantar nerves, right medial and lateral plantar motor nerves. The proximal nerves that were done in this category, such as the right musculocutaneous and axillary, are mostly done for proximal neuropathy. Clearly positive findings on examination could represent a disturbance in these nerves such as seen in shoulder injuries or other kinds of neurological deficits, which include brachial plexus abnormalities. None of these nerves were related to the patient's symptoms or the injury.

The following sensory nerves were also unnecessary: the right saphenous, right deep peroneal, right lateral dorsal cutaneous, right medial calcaneal, left medial calcaneal, left radial sensory, left dorsal cutaneous, left musculocutaneous, left antibrachial cutaneous, right radial sensory, right dorsal cutaneous, right musculocutaneous, right antibrachial cutaneous, left saphenous, left superficial peroneal and left deep peroneal. The sensory nerves that the reviewer included would not be done in a standard EMG that is concerned with the possibility of a cervical radiculopathy with a normal examination. These nerves would be more helpful in separating out brachial

plexopathies from peripheral neuropathies and in some cases radiculopathies. In the lower extremities, the sensory nerves that include the saphenous and others would be done in consideration of peripheral neuropathies or lumbar sacral plexopathies, but not in the obvious radiculopathy that this patient has. Again, the reviewer stresses that EMG testing is not “one size fits all.” It must be correlated with the clinical findings, history, and most probable diagnosis.

The value of somatosensory evoked potentials is becoming less useful since the MRI was introduced in diagnostic testing. Prior to the MRI, it was very difficult to see the spinal cord and as a result the somatosensory testing was more helpful. Somatosensory testing does not offer any further information that the standard nerve conduction, both motor and sensory, and needle examination have to offer.

In summary, the diagnostic electrical testing that was done in this case was excessive and unnecessary for the majority of the nerves that were done. Every nerve that was possibly available in the upper and lower extremities was studied without regard to the patient’s clinical examination and history.

Ziroc has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Ziroc has made no determinations regarding benefits available under the injured employee’s policy

As an officer of ZRC Services, Inc, dba Ziroc, I certify that there is no known conflict between the reviewer, Ziroc and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Ziroc is forwarding this finding by US Postal Service to the TWCC.

Sincerely,