

MDR Tracking Number: M5-04-2856-01

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 133.308 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 dispute was received on May 4, 2004.

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 unlisted diagnostic procedure (95999), and somatosensory testing (95925) rendered on 5/15/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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. As the unlisted diagnostic procedure (95999), and somatosensory testing (95925) were not found to be medically necessary, reimbursement for date of service rendered on 5/15/03 is denied and the Division declines to issue an Order in this dispute.

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

Correspondence submitted by Mobile Diagnostic of Texas revealed Cliff Cain desires to Withdrawal the fee issues. Therefore no further action is required on CPT codes 95904, 95900, 95861 and 95935 rendered on 5/15/03.

This Decision is hereby issued this 22nd day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

September 17, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: **MDR Tracking #: M5-04-2856-01**
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ----- external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurology and is familiar with the condition and treatment options at issue in this appeal. The ----- physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ----- . The patient reported that while at work he injured his right wrist, right elbow, low back and right hip. On 5/15/03 the patient underwent an EMG/NCV that revealed dermatomal evoked potential evidence of lumbosacral radiculopathy.

Requested Services

Unlisted diagnostic procedure (95999), and somatasensory testing (95925) on 5/15/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Decision and Order 8/11/03
2. EMG/NCV report 5/15/03

Documents Submitted by Respondent:

1. Same as above

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ----- physician reviewer noted that this case concerns a male who sustained a work related injury to his right wrist, right elbow, low back and right hip on ----- . The ----- physician reviewer also noted that the patient had undergone a 2 level EMG, multiple motor/sensory NCVs, F&H wave latencies, and dermatomal SEPs. The ----- physician reviewer indicated that dermatomal SEPs are of minimal/unproven value. The ----- physician reviewer explained that the test was not ordered by the pain center that ordered the NCV/EMG. The ----- physician reviewer also explained that the use of CPT code 95999 is unclear and appears to be a possible duplicate billing of the NCV. Therefore, the ----- physician consultant concluded that the unlisted diagnostic procedure (95999), and somatasensory testing (95925) on 5/15/03 were not medically necessary to treat this patient's condition.

Sincerely,
