MDR Tracking Number: M5-05-0891-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 11-12-04.

The Medical Review 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 sensory nerve conduction test and motor nerve conduction test 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 fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for date of service 11-13-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 7th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO decision

December 31, 2004

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-05-0891-01
IRO #: 5284

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

Specialty IRO 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.

This case was reviewed by a licensed Medical Doctor with a specialty in Neurology. The reviewer is on the TWCC ADL. The Specialty IRO 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 Specialty IRO 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

Ms. ___ is employed as a secretary for the .. She suffered an accident while at work on ___. She was sitting at her desk leaning forward to pick up something when she fell off her chair and struck her head against the desk plus she injured her left shoulder, her neck and her lower back. Ms. ___ underwent several investigations, including skull x-rays, cervical and lumbar x-rays and left shoulder x-rays on the date of her injury. These were negative.

She then came under the care of an orthopedist, Dr. Tijmes, whom she saw on July 31, 2003. Dr. Tijmes diagnosed her with neck pain, cervical herniated nucleus pulposus, left facial contusion, left hip contusion and low back pain. An MRI of the cervical spine done on 07/14/03 showed mild spondylosis with a central posterior herniation of the C6-7 level. An MRI of the left shoulder performed on the same date was negative. An MRI of the lumbar spine also done on 07/14/03 revealed mild lumbar spondylotic changes.

Dr. Tijmes also referred Ms. ___ to Dr. Mireles for an EMG and nerve conduction studies of the upper extremities. The EMG and nerve conduction studies were performed on November 13, 2003. The included bilateral median, ulnar and radial motor responses, bilateral median ulnar and radial sensory responses, bilateral medial nerve and ulnar nerve F-wave latencies, and bilateral medial EMG examination in the upper extremities. The EMG and nerve conduction studies were normal bilaterally.

**Records Reviewed:**

1. Letter addressed to the . from Jan Skinner, MPH, CRC dated 12-13-04.
2. X-rays, including skull, 2 views, shoulder left, 2 views, lumbar spine, 4 views dated 06-19-03.
3. MRI of the left shoulder without contrast. MRI of the lumbar spine without contrast, MRI of the cervical spine without contrast dated 07-14-03.
4. CT scan of the brain 07-14-03.
5. Orthopedic consultation, Jorge Tijmes, M.D. dated 07-31-03.
6. Specific and subsequent medical report, Jorge Tijmes, M.D. dated 10-16-03.
7. Medical report Ruy Mireles, M.D., 11-13-03.
8. EMG and nerve conduction studies 11-13-03.
9. Letter addressed to Medical Business Management Services, Ruy Mireles, M.D. dated 12-03-03.
10. Hand written prescription Francisco Pena, M.D. dated 11-13-03 addressed to Dr. Mireles.

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of (95904) sensory nerve conduction test and (95900) motor nerve conduction test on 11-13-2003.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

Ms. ___ suffered a work-related injury on ___ when she fell off her chair at work. She apparently struck her head against the desk plus injuring her neck, left shoulder, left upper extremity and lower back. She has symptoms of burning pain in her left shoulder. She underwent a workup for a cervical radiculopathy. MR imaging showed non-specific mild degenerative changes of the cervical spine. X-rays and MRI of the left shoulder were negative.

It was appropriate that Ms. ___ underwent an EMG and nerve conduction studies of the left upper extremity to rule-out a cervical radiculopathy, brachial plexopathy or peripheral nerve entrapment. However, given the findings that the EMG and nerve conduction studies of the left upper extremity were normal, there was no medical need or reason to examine the right upper extremity.

**References:**


1. American Association for Diagnostic Medicine Guidelines for Electrodiagnostic Consultation 02-03.
2. American College of Occupational Medicine, Occupational Medcine Guidelines, 2004


Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

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

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director