

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	Response Timely Filed? ( ) Yes (X) No
Requestor's Name and Address Craig A. Thiry, D. C. 2656 S. Loop W. Ste 270 Houston, TX 77054	MDR Tracking No.: M5-05-2030-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
12-29-04	12-29-04	CPT codes 95900, 95903, 95904, 95934-H, 95861	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

### PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

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

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues.

### PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Ordered by:

Donna D. Auby

6-6-05

Authorized Signature

Typed Name

Date of Order

### PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

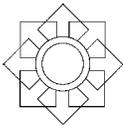
Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_

## PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**



## Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 • 901 Mopac Expressway South • Austin, Texas 78746-5799  
phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

### NOTICE OF INDEPENDENT REVIEW DECISION

June 2, 2005

Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Injured Worker: \_\_\_\_\_  
MDR Tracking #: M5-05-2030-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

#### Clinical History

This 42 year-old male injured his back on \_\_\_\_\_. He has complaints of intermittent pain, headache and sleep disturbances due to pain. He has been treated with medications, therapy and surgery.

#### Requested Service(s)

Motor nerve conduction test (95900, 95903, and 95904), H-reflex test, muscle test, 2 limbs for date of service 12/29/04

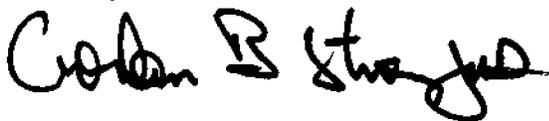
#### Decision

It is determined that there is medical necessity for the motor nerve conduction test (95900, 95903, and 95904), H-reflex test, and muscle test, 2 limbs for date of service 12/29/04 to treat this patient's medical condition.

#### Rationale/Basis for Decision

Medical record documentation indicates intermittent pain shooting down his arms into his hands with tingling, numbness and weakness even after surgical intervention. Objective findings in the form of continued decreased cervical range of motion, pain on palpation, sensory decreased along C5-6 dermatomes, biceps and brachioradialis reflexes are decreased bilaterally and hand grip strength is weaker on the right side. All of these subjective and objective radicular findings indicate the need for this testing. Therefore, the motor nerve conduction test (95900, 95903, and 95904), H-reflex test, muscle test, 2 limbs for date of service 12/29/04 is medically necessary to treat this patient's medical condition.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." in a cursive style.

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:dm

Attachment

**Information Submitted to TMF for TWCC Review**

**Patient Name:** \_\_\_\_

**TWCC ID #:** M5-05-2030-01

**Information Submitted by Requestor:**

- Requestor's Position
- Progress Notes
- Diagnostic Tests
- Procedure Note
- Claims

**Information Submitted by Respondent:**

-