



Texas Department of Insurance, Division of Workers' Compensation
 7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Neuroscience Centers Inc. 1509 Falcon Drive, Suite 106 Desoto, Texas 75115	MDR Tracking No.: M5-05-2989-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Dallas Fire Insurance Company, Box 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary stated, "I respectfully request that your office assign an IRO and that you enter a Decision and Findings citing that Dallas Fire Insurance did not comply with Rule 133.304."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "There simply is no medical documentation to substantiate the medical necessity for the treatments provided by the Requestor as the Claimant has already reached MMI. The Requestor should not be entitled to any reimbursement for the disputed treatments or services."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
1-28-05	CPT codes 95860, 95903, 95904, 95934	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0

PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution 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 did not prevail on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

10-13-05

Authorized Signature

Typed Name

Date of Findings and Decision

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

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

NOTICE OF INDEPENDENT REVIEW DECISION

September 27, 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 #: M5-05-2989
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 patient suffered a work-related injury on ___ when he fell on his back and fell forwards injuring his back and twisting his left knee. The patient has been treated with therapy, medications, and surgery.

Requested Service(s)

EMG-one extremity & paraspinal area, nerve conduction with F wave study, nerve conduction each nerve-sensory, and H reflex study for date of service 01/28/2005.

Decision

It is determined that there is no medical necessity for the EMG-one extremity & paraspinal area, nerve conduction with F wave study, nerve conduction each nerve-sensory, and H reflex study for date of service 01/28/2005 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient was injured in a work related event and began conservative treatment. Subjective symptoms indicated a considerable amount of back pain with left sacroiliac pain. Objective findings from a neurological exam were negative and reflexes were present and equal. There are no indications from progress notes, initial reports, or re-evaluation to indicate the need for the services in question. National treatment guidelines do not allow for this type of testing when there is not sufficient clinical documentation of positive findings. Therefore, the EMG-one extremity & paraspinal area, nerve conduction with F wave study, nerve conduction each nerve-sensory, and H reflex study for date of service 01/28/2005 is not medically necessary to treat this patient's medical condition.

Sincerely,

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