



**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

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:  Health and Medical Practice Associates 324 N. 23 <sup>rd</sup> St. Ste. 201 Beaumont, TX 77707	MDR Tracking No.: M5-06-0933-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Hartford Underwriters Insurance, Box 27	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "We disagree with the decision of the insurance carrier and the reason you give for denial – 'documentation does not support the treatment to be medically reasonable and/or necessary.'"

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response received.

#### 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)
2-23-05 – 6-6-05	CPT code 95900 -WP (\$74.59 X 6 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$447.54
2-23-05 – 6-6-05	CPT code 95904 -WP (\$63.75 X 6 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$382.50
2-23-05 – 6-6-05	CPT code 95903 (\$80.83 X 4 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$323.32
2-23-05 – 6-6-05	CPT code 95860	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$108.64
	Grand Total		\$1,262.00

#### 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 prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$1,262.00.

CPT code 97530 on 6-6-05 was denied as "W1-WC State Fee Schedule Adjustment. Reimbursement according to the TX Medical Fee Guidelines." The requestor billed for two units of this service. The carrier reimbursed the requestor for one unit, however, it gave no valid reason for not reimbursing for the outstanding unit. The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement per Rule 134.202(c)(1) of \$35.34.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.307(g)(3)(A-F), 133.308 and 134.202(c)(1).

**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 carrier must refund the amount of the IRO fee (\$650.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to additional reimbursement in the amount of 1,297.34. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision and Order by:

Donna Auby

4-10-06

Authorized Signature

Typed Name

Date of Order

**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.**

April 4, 2006

Texas Department of Insurance Division of Texas Worker's Compensation  
MS48  
7551 Metro Center Drive, Suite 100  
Austin, Texas 78744-1609

### **NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-06-0933-01**

**DWC #:**

**Injured Employee:**

**Requestor: Health and Medical Practice Association**

**Respondent: Hartford Underwriters Insurance**

**MAXIMUS Case #: TW06-0021**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. The TDI, Division of Workers Compensation (DWC) has assigned this case to MAXIMUS in accordance with Rule §133.308, which allows for a dispute resolution by an IRO.

MAXIMUS 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 who is board certified in neurology on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the approved doctor list (ADL) of DWC or has been approved as an exception to the ADL requirement. A certification was signed that the reviewing provider has no known conflicts of interest between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO, was signed. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

### **Clinical History**

This case concerns an adult male who sustained a work related injury on \_\_\_\_\_. The patient reported that while driving a truck, he was involved in a motor vehicle accident. He also reported he felt immediate pain in his neck, mid and low back and both shoulders. Diagnoses included cervical and thoracic strain, and right shoulder impingement syndrome. Evaluation and treatment have included physical therapy, MRI, electromyography, nerve conduction velocity tests, injections, surgery and medications.

### **Requested Services**

Nerve conduction test – no F wave (95900-WP), sensory testing-each (95904-WP), motor nerve conduction test (95903) and muscle test, one limb (95860) on 2/23/05.

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

*Documents Submitted by Requestor:*

1. Diagnostic Studies (e.g., MRI, etc.) – 1/5/04
2. Functional Capacity Evaluation – 12/15/03
3. Electromyography and Nerve Conduction Velocity Testing – 2/23/05
4. Articles and Literature about Electrodiagnostic Medicine – not dated

5. Health and Medical Practice Associates Correspondence and Records – 12/2/03-4/6/05
6. Orthopedic Correspondence and Records – 12/17/04, 3/16/05, 3/25/05, 4/1/05, 4/29/05, 6/24/05
7. Operative Reports – 3/30/04, 3/31/04, 4/1/04, 9/27/04, 8/23/04

*Documents Submitted by Respondent:*

1. Designated Doctor Evaluations – 8/23/05, 12/21/05
2. Health and Medical Practice Associates Correspondence and Records – 11/20/03 – 1/11/05
3. Orthopedic Correspondence and Records – 6/29/05
4. Determination Notice – 2/1/05
5. Operative Reports – 3/30/04, 3/31/04, 4/1/04
6. Hospital Records – 4/1/04
7. Laboratory Reports – 1/19/04, 2/10/04
8. Chiropractic Correspondence and Records – 3/1/04
9. Therapy Records – 10/27/03-12/12/03
10. Diagnostic Studies (e.g., MRI, etc.) – 1/5/04

### **Decision**

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

### **Standard of Review**

**This MAXIMUS determination is based upon generally accepted standard and medical literature regarding the condition and services/supplies in the appeal.**

### **Rationale/Basis for Decision**

The MAXIMUS physician consultant indicated the patient was treated with physical therapy and seen by orthopedic consultants. The MAXIMUS physician consultant explained he had MRIs of the cervical spine and electromyography. The MAXIMUS physician consultant noted that the indications for electrodiagnostic testing are set by the American Association of Electrodiagnostic Medicine and include several potential diagnoses including neck pain radiating to an extremity. The MAXIMUS physician consultant noted that the suspicion of cervical radiculopathy would be appropriately worked by with electrodiagnostic testing. The MAXIMUS physician consultant indicated the American Association of Electrodiagnostic Medicine has created guidelines for the number of motor and sensory nerves required for any given potential diagnosis. The MAXIMUS physician consultant explained that for cervical radiculopathy, three motor units (95900), two motor units (95903) are appropriate as well as one extremity EMG.

Therefore, the MAXIMUS physician consultant concluded that the Nerve conduction test – no F wave (95900-WP), sensory testing-each (95904-WP), motor nerve conduction test (95903) and muscle test, one limb (95860) on 2/23/05 were medically necessary for treatment of the member's condition.

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Sincerely,  
**MAXIMUS**

Lisa Gebbie, MS, RN  
State Appeals Department