



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

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestors Name and Address: Health and Medical Practice Associates 324 N. 23 rd St. Ste. 201 Beaumont, TX 77707	MDR Tracking No.: M5-06-2185-01
	Claim 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: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "Please see copy of our denials of payment for dates of services above. The denials states, 'claim/service lacks information which is needed for adjudication...' We strongly disagree with these denials."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: Position statement submitted by Texas Mutual does not address the disputed issues.

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. EOB's

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)
2-9-06	95900-59	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
2-9-06	95904-WP	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
2-9-06	95903	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
2-9-06	95860	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Total Due		\$0.00

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 not prevail on the disputed medical necessity issues. No reimbursement recommended.

Regarding CPT code 95900-59 on 2-9-06: the Respondent's position paper states, "Health and Medical Practice Associates has filed with the Division a request for medical dispute resolution involving the amount of payment due for services rendered by Provider and/or medical necessity." The IRO decision affirmed that these services were not medically necessary and reimbursement was not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d) and 413.031
28 Texas Administrative Code Sec, 133.308 and 134.1

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 Division has determined that the Requestor is not entitled to reimbursement of the IRO fee and is not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

Medical Dispute Officer

11-30-06

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.

ZRC MEDICAL RESOLUTIONS

November 15, 2006

Re: MDR #: M5 06 2185 01 Injured Employee: ___
DWC #: ___ DOI: ___
IRO Cert. #: 5340 SS#: ___

TRANSMITTED VIA FAX TO:

TDI, Division of Workers' Compensation

Attention: ___

Medical Dispute Resolution

Fax: (512) 804-4868

RESPONDENT: Texas Mutual Insurance

REQUESTOR: Health and Medical Practice Assoc.

TREATING DOCTOR: Patrick McMeans, MD

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to ZRC Medical Resolutions for an independent review. ZRC has performed an independent review of the medical records to determine medical necessity. In performing this review, ZRC reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the president of ZRC Medical Resolutions, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in neurology and is currently listed on the DWC Approved Doctor List.

This decision by ZRC Medical Resolutions, Inc. is deemed to be a DWC decision and order.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision, the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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.

Sincerely,
Jeff Cunningham, DC
President

REVIEWER'S REPORT CASE NUMBER

MEDICAL INFORMATION REVIEWED:

1. Initial notification of the IRO assignment.
2. Information forwarded by Texas Department of Insurance Division of Workers' Compensation as it relates to the requestor, which is Health and Medical Practice, and the respondent, which is Texas Mutual Insurance Company, and ZRC Medical Resolutions as the independent review organization
3. Information that was forwarded by the Health and Medical Practice Associates of Beaumont, Texas to ZRC Medical Resolutions at the above-stated address with reference to ____, Case #M5-06-2185-01, date of injury is ____
4. A copy of the results of a nerve conduction velocity and EMG report dated 02/09/06, which will be discussed in detail later
5. Notes titled Medical Progress Notes that begin in 2004 and are monthly or near-monthly results, the last of which I see end on 09/07/06
6. Operative report, various MRI scan findings, and the health service claim form

BRIEF CLINICAL HISTORY:

This is a male in his mid-30s who had a work-related injury of his left wrist on _____. The patient underwent extensive evaluation and various orthopedic treatments. During the course of the patient's treatments, he obtained a nerve conduction velocity and EMG study as well as f-wave assessment of his right and left upper extremities.

DISPUTED SERVICES:

The nerve conduction velocity (95900-59), nerve conduction (95904-WP) sensory each nerve, nerve conduction (95903) and needle electromyography studies (95860).

DECISION:

I AGREE WITH THE DETERMINATION MADE BY INSURANCE CARRIER IN THIS CASE.

RATIONALE OR BASIS FOR DECISION:

On the basis of pure medical documentation, I do not fully understand the rationale for obtaining nerve conduction velocity and EMG studies in this case. There was early mention on 07/09/04 by Dr. Todd Clark that EMG and nerve conduction studies could possibly be checked in the future. There is a long history of notes including various treatments that report ongoing pain and apparent numbness as well as tingling and difficulty with use of his left hand. No neurologic examination can be found in terms of specific strength testing or sensory modalities. Further, it should be noted that the patient had EMG and nerve conduction studies of his unaffected upper extremity (right upper extremity) for reasons that are unclear and probably do not meet the test of medical necessity. Additional findings include that the diagnostic codes used to justify the procedures that are in dispute are for an 814.01 fracture, navicular, wrist, and an 842.00, which is strain/strain, wrist.