

January 24, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2 03 0101 01
IRO #: 5251

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

___ has performed an independent review of the proposed care 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 Doctor of Chiropractic. The ___ 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 ___ 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

___ was injured on his job with ___ on ___ when he suffered a sprain/strain injury to the mid back and left shoulder. The documentation of this file is very minimal, consisting of almost no medical records and 2 letters of medical necessity from the treating doctor explaining the efficacy of Surface EMG. The one office note that was included was from June 20, 2002 and indicated the patient had somatic injuries and was undergoing passive care at that point. The first letter from the treating doctor indicates the necessity of the SEMG by describing the test equipment used. The second describes the theory behind SEMG and the reasons it is used.

REQUESTED SERVICE

The carrier has declined a Kinesiologic Surface EMG.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

There is no documentation from the treating doctor about the condition of the patient and why such testing is needed for this patient. There is no description of what treatment or testing has been performed nor of why this particular test was chosen to be utilized. Most importantly, there is not one piece of information in the minimal documentation that would indicate what result this test would have on the patient's treatment plan and how the information gleaned from this test would be integrated into the patient's future medical program. This patient apparently has a sprain/strain and I can think of no reason to perform this test on a patient with that type of injury lacking a clear direction of a treatment plan.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

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

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request. The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).