



Texas Medical Foundation

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phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

September 24, 2004

Requestor

Respondent

Metropolitan Transit Authority
Attn: Katie Foster
505 W. 12th Street
Austin, TX 78701

RE: Injured Worker:
MDR Tracking #: M2-04-1787-01
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 proposed 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 care. 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 32 year-old male was injured in a motor vehicle accident on 08/___/03. He was the seat belted driver of a metro bus that rear ended another vehicle, he was jolted back and forth during the accident and sustained multiple injuries to different anatomical regions of the body. He continues to have neck pain and back pain radiating to the upper and lower extremities. He has been treated with therapy.

Requested Service(s)

Electromagnetic generator/nerve conduction velocity (EMG/NCV) Upper and Lower Extremity X1.

Decision

It is determined that the electromagnetic generator/nerve conduction velocity (EMG/NCV) Upper and Lower Extremity X1 is not medically necessary to evaluate this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates normal ranges of motion, an absence of negative neurological findings and no past or present symptoms, complaints or physical findings or objective testing that indicates the test is warranted. Therefore, the proposed EMG/NCV of the upper and lower extremity is not medically necessary to evaluate this patient's medical condition.

This decision by the IRO is deemed to be a TWCC decision and order.

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.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,

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

cc: Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 24th day of September, 2004.

Signature of IRO Employee:

Printed Name of IRO Employee: