

October 19, 2004

Re: MDR #: M2-05-0112-01
IRO #: 5055

TRANSMITTED VIA FAX TO:

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Dear ____

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ____ for an independent review. ____ has performed an independent review of the medical records to determine medical necessity. In performing this review, ____ 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 Secretary and General of ____ 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 any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to 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 Board Certified in Physical Medicine & Rehab and in Pain Management and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

- letter of medical necessity 09/08/04
- office notes 07/12/04 – 08/26/04
- nerve conduction study 03/19/04

Information provided by Respondent:

- physician exams 03/15/04 & 06/10/04

Information provided by Orthopedic Surgeon:

- office notes 06/11/03 – 06/23/04

Clinical History:

The claimant sustained an injury on ____, which resulted in injury to the forearms and hands as well as the low back. The patient had a negative EMG/NCV in March of 2004. His treating doctor noted progressive left upper extremity muscle

weakness and paresthesias with decreased circumference of the left forearm as compared to the right on 7/12/04.

Disputed Services:

Repeat bilateral upper extremity EMG/NCV

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that repeat bilateral upper extremity EMG/NCV is medically necessary in this case.

Rationale:

The patient has documented progressive muscle atrophy and weakness present in the left forearm with deterioration of functional ability also documented. It is, therefore, appropriate to get a repeat EMG/NCV to assess for pathology.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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 Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

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

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 October 19, 2004.