



Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

March 23, 2005

Requestor

Jacob Rosenstein, MD
ATTN: Cheryl
800 W. Arbrook, Ste 150
Arlington, TX 76015

Respondent

Ace Insurance Company of Texas
ATTN: Javier Gonzalez
Fax#: (512) 394-1412

Injured Worker:
MDR Tracking #: M2-05-0922-01
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 Medicine. 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 45 year-old male injured his low back on ____ when he slipped, fell and landed on his coccyx and then lost consciousness. He was diagnosed with a ruptured disc that warranted surgery. He underwent surgery, post surgical rehabilitation, and returned to full-time employment. In October 2003 he developed a significant relapse that has been determined is related to his original injury. He complains of low back pain, left leg soreness and tingling on the bottom of his left foot. He has been treated with medications and therapy.

Requested Service(s)

Proposed Electromyogram/Nerve Conduction Velocity (EMG/NCV) of both lower extremities

Decision

It is determined there is medical necessity for the proposed EMG/NVC of both lower extremities to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient was injured on the job in _____. In 2003, he experienced a significant relapse that has been determined is related to his original injury. An independent medical examination was performed that recommended an EMG/NVC of the lower extremities. National treatment

guidelines allow for this type of testing in this type of ongoing lumbar radiculopathy. The patient's current condition meets and exceeds the minimal criteria required for performing the tests in question. Therefore, the proposed EMG/NCV of both lower extremities is medically necessary to treat 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

GBS:vn

Attachment

cc: Injured Worker
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 23rd day of March 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M2-05-0922-01

Information Submitted by Requestor:

- Progress Notes

Information Submitted by Respondent:

- Independent Review (2004)
- Emergency Room Records (2003)
- Diagnostic Tests (1997 – 1998 and 2003 – 2005)
- Progress Notes (1997 – 1998 and 2003 – 2005)
- Consult (1997)
- Designated Doctor Evaluation (1997)
- Maximum Medical Improvement Rating (1998)
- Operative Report and Hospital Records (1997)
- Work Hardening Program (1997)
- Claims (1997 – 1998 and 2003 – 2005)