



Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

April 22, 2005

Requestor

Pedro Nosnik, MD, PA
Attn: Marsha Moriarty
4100 W. 15th Street, Suite 206
Plano, TX 75093

Respondent

Chubb Insurance
Attn: Mark Sickles
P.O. Box 162443
Austin, TX 78716

RE: Injured Worker: _____
MDR Tracking #: M2-05-1156-01
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 TMF physician reviewer who is board certified in neurology, by the American Board of Medical Specialties, licensed by the Texas State Board of Medical Examiners (TSBME) in 1976, and who provides health care to injured workers. This is the same specialty as the treating physician. The TMF physician reviewer 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 37 year-old female injured her shoulder on _____. She complains of difficulty with neck motion, occipital headaches and radicular pain down the left arm into all her fingers on that hand. She has been treated with therapy and medications.

Requested Service(s)

Proposed Electromyogram (EMG)/Nerve Conduction Velocity (NCV) bilateral upper

Decision

It is determined that there is medical necessity for the proposed Electromyogram (EMG)/Nerve Conduction Velocity (NCV) bilateral upper to treat this patient's medical condition.

Rationale/Basis for Decision

Electromyography tests the integrity of the entire motor system. Different muscle groups may be selected for examination according to the clinical symptoms and signs of the patient. The diagnosis of radicular injuries is based on clinical examination and electrophysiologic studies which help delineate the distribution of the affected muscles. Needle studies, as an extension of the physical examination, help to further localize the level, extent, and tonicity of involvement. They are also useful in making clinical decisions regarding treatment options.

The Medical record documentation indicates a diagnosis consistent with a chronic left upper extremity cervical radiculopathy. The patient has had two prior electromyogram studies with the most recent one revealing chronic C5-6 changes. Minor carpal tunnel slowing was noted on the original (NCV). This patient's symptoms have intensified and are associated with subjective loss of sensation and objective weakness and diminished reflexes. On the basis of worsening symptoms and appropriate physical findings a cervical radiculopathy is present. Therefore, the proposed Electromyogram (EMG)/Nerve Conduction Velocity (NCV) bilateral upper is medically necessary to treat this patient's 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 22nd day of April 2004.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M2-05-1156-01

Information Submitted by Requestor:

- Progress Notes
- Peer Review
- Diagnostic Tests
- Consults
- Claims/Miscellaneous

Information Submitted by Respondent:

- Peer Review
- Claims/Miscellaneous