

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-1297-01
Name of Patient:	
Name of URA/Payer:	Fire & Casualty Insurance Company
Name of Provider: (ER, Hospital, or Other Facility)	Advanced Neurological Centers
Name of Physician: (Treating or Requesting)	Thao Huynh, DC

May 9, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc:

Advanced Neurological Centers
Thao Huynh, DC
Texas Workers Compensation Commission

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Correspondence from the provider
2. Carrier reviews
3. Research studies
4. Diagnostic imaging reports
5. Operative report
6. Report of William R. Francis, Jr., M.D.
7. EMG/NCV report

Patient underwent diagnostic imaging, EMG/NCV and lumbar surgery after being injured on ___ while lifting a heavy metal frame to load it onto a palate.

REQUESTED SERVICE(S)

Prospective medical necessity of repeat EMG/NCV of bilateral lower extremities.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

The carrier reviewer stated, "ACOEM is clear regarding the indication of electrodiagnostic studies, and they should only be performed when there are subtle but consistent findings with regards to motor, reflex and sensory findings that need some objectification." That is not an applicable basis for denial since claimant in this case did in fact exhibit "motor, reflex and sensory findings." Based on those findings and due to the need to obtain "some objectification" in order to determine the best course of future treatment, the proposed EMG/NCV testing is both indicated and medically necessary under the very guidelines

referenced by the carrier reviewer. The medical necessity of the proposed tests is also supported by the Milliman Care Guidelines¹ that state electrodiagnostic testing is indicated for disorders of the peripheral nervous system when there is (1) a potential diagnosis of lumbar radiculopathy involving neurologic symptoms and (2) a lack of response to prior treatment.

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 (20 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 **20** (twenty) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a 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

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

¹ Milliman Care Guidelines, *Ambulatory Care* 8th Edition. Copyright © 1996, 1997, 1999, 2001, 2002 Milliman USA, Inc.

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 10th day of May 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell