THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-9160.M5

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address Crowne Chiropractic 2810 South Cooper Arlington TX 76015	MDR Tracking No.: M5-05-1420-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Box 19 American Home Assurance PO BOX 13367 - CAPITOL STATION AUSTIN TX 78711	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	**To**		
1-2-04	**4-21-04**	**98940, 99212, 99214, 97018, 97032, 97035**	☐ **Yes** ☒ **No**
1-2-04	**4-21-04**	**A4595-RR**	☒ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail on the majority of the disputed medical necessity issues. The IRO deemed the TENS supply A4595-RR was medically necessary. Per the 2004 DMEPOS Fee Schedule, the reimbursement is $28.81 x 125% = $36.01.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 4-28-05 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Services rendered on 1-27-04 and 2-2-04 were denied as N-not documented or insufficient. Requestor submitted office visit notes that documented the services rendered. Recommend reimbursement as follows:

99212 $37.32 x 125% = $46.65 x 2 DOS = $93.30

97018 $6.64 x 125% = $8.30 x 2 DOS = $16.60

97032 $15.57 x 125% = $19.46 x 2 DOS = $38.92

97035 $12.24 x 125% = $15.30 x 2 DOS = $30.60

$179.42

Services rendered on 2-6-04 were denied as N-not documented or insufficient. Per Rule 133.307(g)(3)(B), the requestor did not submit copies of pertinent medical records or other documents relevant to this date of service. Therefore, this date of service cannot be reviewed and no reimbursement recommended.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement of $36.01 + $179.42 = $215.43 for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Authorized Signature	Typed Name	7-6-05 Date of Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: 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. A request for a hearing must be in writing and the TWCC Chief Clerk of Proceedings/Appeals Clerk must receive it within 20 days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representative's box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

Z iro C

A Division of ZRC Services, Inc.
7626 Parkview Circle
Austin, Texas 78731
Phone: 512-346-5040
Fax: 512-692-2924

June 28, 2005

TWCC Medical Dispute Resolution
Fax: (512) 804-4868

Patient:	___
TWCC #:	___
MDR Tracking #:	M5-05-1420-01
IRO #:	5251

Ziroc has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Ziroc for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Ziroc has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed provider board certified and specialized in Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The Ziroc health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Ziroc for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by Requestor, Respondent, and Treating Doctor including: Progress report from treating doctor, letter of medical necessity for MD review, office notes from treating doctor, EOB's, Explanation of reviews.

CLINICAL HISTORY

This is a 40-year old female with a date of injury of ___. This patient had right carpel tunnel release on 11/27/01 and left carpel tunnel release on 3/7/02. The Designated Doctor who put her at Maximum Medical Improvement on 7/16/02 returned her to full duty without restrictions on 8/2/02.

DISPUTED SERVICE(S)

Under dispute is the Retrospective medical necessity of chiropractic manipulative treatment, office visits, paraffin bath, electrical stimulation-manual, ultrasound, TENS supply during the dates 1/2/04 through 4/21/04.

DETERMINATION/DECISION

The Reviewer partially agrees with the determination of the insurance carrier.

The Reviewer agrees with the insurance company on the chiropractic manipulative treatment, office visits, paraffin bath, electrical stimulation-manual, and ultrasound for the disputed dates. The Reviewer disagrees with the insurance company for the use of TENS supply for the disputed dates.

RATIONALE/BASIS FOR THE DECISION

In the Reviewer's opinion, the services requested are unreasonable and unnecessary. The treatment in dispute would be given to this patient for an acute injury for palliative reasons. This exacerbation of symptoms is 4 years post injury and from the surgical information provided has led to scar tissue formation, reproducing the original nerve entrapment symptomotology. These lower levels of treatment are in agreement for an acute injury according to the Mercy Guidelines, Texas Guidelines for Quality Assurance and Practice Parameters, and Texas Workers Compensation Upper Extremity Treatment Guidelines §134.1002. However, this does not fit the criteria for a chronic injury, nor a stabilized injury with exacerbations. During the course of active treatment this patient should have gone through an active rehab program after her post surgical therapy to reduce scar tissue formation, and increase range of motion, endurance and strength. After the completion of a rehab program, this patient could have been educated for a home rehab program that would prevent re-injury and would have formed awareness for an increase of therapy if the slightest of symptoms returned. It appears this patient was not introduced to any kind of injury prevention program where the employee is educated on various stretches to perform in the workday during 'micro breaks'. This would have reduced re-injury and doctor dependence. In the Reviewer's opinion the use of the TENS unit is reasonable and necessary for this type of "flare-up", but would suggest that there should be some patient education on the use of this and not over utilized as a palliative treatment instead of a home rehab/exercise program.

Screening Criteria

1. Specific: Mercy Guidelines, Texas Guidelines for Quality Assurance and Practice Parameters, and Texas Workers Compensation Upper Extremity Treatment Guidelines §134.1002

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by TWCC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized

standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

Ziroc has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Ziroc has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ZRC Services, Inc, dba Ziroc, I certify that there is no known conflict between the Reviewer, Ziroc and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Ziroc is forwarding by mail or facsimile, a copy of this finding to the TWCC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,
ZRC Services Inc

Dr. Roger Glenn Brown
Chairman & CEO