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 Metro Radiology Imaging Inc 1711 W. Irving Blvd #304 Irving TX 75061	MDR Tracking No.: M5-05-1864-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Rep Box 54 Texas Mutual Insurance 221 W. 6th Street Suite 300 Austin TX 78701	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**		
3-9-04	**3-9-04**	**72141-WP**	☒ **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 **prevailed** on the disputed medical necessity issues.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of $460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and $553.28 X 125% = $691.60 for the services in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20 days of receipt of this Order.

Ordered by:

		7-11-05
Authorized Signature		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.

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

June 22, 2005

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

Patient:	___
TWCC #:	
MDR Tracking #:	M5-05-1864-01
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 care rendered 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

Information from Requestor, Respondent, and Treating Doctor including: Consulting physicians, MMI reports. Records reviewed that were most helpful were the treating physician's progress notes, consulting physicians progress notes, and a copy of the cervical MRI report.

CLINICAL HISTORY

This employee injured her neck and left shoulder, left knee and lower back when she fell backwards and to the left, landing on her left side. This occurred when she was trying to pull a child, with whom she was having discipline problems, on a blanket out of a doorway. The Injured Employee was a supervisor of a classroom at the .

DISPUTED SERVICE(S)

Under dispute is the prospective medical necessity of cervical magnetic resonance imaging (MRI) without contrast.

DETERMINATION/DECISION

The Reviewer disagrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

Based on the clinical evidence, the Reviewer concluded that the treating physician was correct in ordering the cervical MRI. The patient continued with neck pain 6 ½ weeks post injury. The carrier states in their position paper that cervical MRI was not necessary because there were no radiating symptoms; however, it is the Reviewer's opinion that the patient's pain pattern indeed reflected cervical disc injury. Dr. Townsend, a consulting physician, remarked in his note of 2-9-2004 (predating the MRI) that the neck pain "radiated down to the trapezius and supraspinatus muscle areas and out into the shoulder as well as radiating down the left upper extremity as far as the forearm and wrist. This statement in the medical record clearly contradicts the carriers opinion that "there was no evidence of radiating pain leading up to the MRI…".

Further, the carrier utilizes a "Treatment Query" from CMS as a guideline on when to order MRI. The Reviewer has reviewed the CMS document and find that leniency was taken with the document by the carrier. In fact, the carrier used a statement that "723.1" cervicalgia is not an approved diagnosis under CMS guidelines to order or justify an MRI. The Reviewer

agrees that statement is taken from the CMS guideline except that the treating and consulting physicians are correct to not diagnose radiculopathy or cervical herniation, two of the "approved diagnostic codes" under the CMS guidelines, until they are certain of the diagnosis. Cervical MRI renders the ability to give a certain diagnosis in this case. Moreover, closer scrutiny of the CMS guideline reveals that it is only that, not a recipe book, but a guideline, and that there is much room for clinical decision making by the provider. Therefore, the carrier's position regarding use of the CMS guidelines is incorrect. Furthermore, the carrier mentions that "there was not documentation of significant neurological deficit or signs or sensory deficit to support early intervention." Absence of "significant neurological deficit or signs or sensory deficit" are not necessary findings to necessitate an MRI. In fact, ongoing symptoms of the nature the injured employee complained of 6 ½ weeks post injury warranted further examination. In any event, the Reviewer concludes that the treating and consulting physicians were prudent in ordering the cervical MRI. In fact, the results of the MRI were positive for disc pathology and did alter the course of care the patient received.

Screening Criteria

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 a copy of this finding by facsimile to the TWCC.

Sincerely,
ZRC Services Inc

Dr Roger Glenn Brown
Chairman & CEO