

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NO.:**

SOAH DOCKET NO. 453-05-9024.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
Requestors Name and Address Main Rehab & Diagnostic 3500 Oak Lawn Suite 308 Dallas TX 75219	MDR Tracking No.: M5-05-2049-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Rep Box 47 American Casualty Company	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		
3-30-04	6-18-04	97750-FC, 99211, 97545-WH-CA, 97546-WH-CA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6-18-04	6-18-04	99455-V5-WP	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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 disputed medical necessity issues.

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.

Code 99455-V5-WP billed on 6-18-05 was denied as unnecessary medical. This code is for a TWCC required service and not subject to an IRO review; therefore the carrier denied inappropriately. The billing of code 99455-V5-WP is in compliance with Rule 134.202(e)(6)(C)(i)(II) and (D)(iii)(II); therefore, recommend reimbursement of \$118.14 x 125% = \$147.68 + \$150.00 = \$297.68.

PART IV: COMMISSION DECISION & ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement for the medical necessity services involved in this dispute and is not entitled to a refund of the paid IRO fee. The Division hereby ORDERS the insurance carrier to remit \$297.68 for the fee portion 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.

Findings, Decision & Order 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 & Order 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 24, 2005

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

Patient: _____
TWCC #: _____
MDR Tracking #: M5-05-2049-01
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 Providet 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: Correspondence, examination reports, FCE reports, psychological evaluation report, office notes, work hardening program notes, Respondent: IME report, peer review report, DDE report, and Treating Doctor, including: Notification of IRO Assignment.

CLINICAL HISTORY

The records indicate the patient was injured on the job on ___ when two boxes of lettuce fell on her causing injuries to her neck, left shoulder and left forearm. The patient received treatment the next day by a doctor who prescribed medication and started therapy. The patient missed a few days of work and was to continue therapy and return to work light duty.

DISPUTED SERVICE(S)

Under dispute is the medical necessity of 97750FCQU Functional Capacity Eval, 99211 OV, 97545 WH-CA-QU Work Hardening, 97546 WH-CA-QU Work Hardening-additional hours from 3-30-2004 through 6-18-2004

DETERMINATION/DECISION

The Reviewer agrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

The patient was initially evaluated and an aggressive treatment program was rendered. An IME evaluation report dated 9-20-2003 indicated the patient should have responded to care and should have been placed at MMI within 4 to 6 weeks of date of injury. The patient continued to receive treatment and was seen by a designated doctor on 12-4-03 who indicated the patient was not at MMI and recommended injections and surgical evaluation. He felt if surgery were not needed then a work conditioning/hardening program would be in order. The patient must have changed treating doctors as there is a new patient exam report dated 1-22-04. The treating doctor referred her to other doctors for evaluation and medication management. The patient was also referred to an orthopedist for a surgical consultation. On 2-16-04 the patient received an injection. The injection helped and it was determined the patient was not a surgical candidate. Another DDE exam on 03/24/04 found the patient had reached MMI. The FCF on 3-30-04 revealed the patient was at a sedentary level with regard to her work status. It is difficult for The Reviewer to put much validity in this FCE. This patient had received an enormous amount of treatment since her injury and with all the treatment the FCE indicated the patient was only at the sedentary level. Self care, normal ADL's, ability to drive, help with care of family members and minimal duties around one's household usually require more than a sedentary level. The records do not indicate this patient was bedfast or that the patient was unable to perform her normal ADL's. In fact the Oswestry Daily Living Assessment and Oswestry Pain Disability index completed on 03-30-04 indicates her pain prevents her from lifting heavy weights, the patient can manage light to medium weights if they are positioned conveniently. Psychological testing revealed a psychological overlay. The treating doctor then decided this patient needed an intensive 6 weeks multidiscipline work hardening program to address her continued problems. This was performed.

Based upon the review of the records, The Reviewer determined there were not sufficient clinical findings to justify the intensive 6 weeks work hardening program. The FCE revealed the patient was at sedentary level of work status. As mentioned above, The Reviewer found it difficult to believe the patient was only at sedentary level especially since the patient started in her assessment and index the patient could lift light to medium weights if they are positioned conveniently. In the event the test truly confirmed her sedentary status, then a combination of 4 hours of work conditioning and 4 hours of restricted work for two to four weeks should have been sufficient to have progressed this lady from a sedentary level; to a light level of work status. Psychological issues should have been able to be adequately addressed with four to six one hour weekly individual sessions and there was no medical necessity for her to participate in a multidiscipline work hardening program

Screening Criteria

1. Specific:
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. Screening criteria should be cited in each review of medical necessity.

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