

IRO America Inc.

An Independent Review Organization

(IRO America Inc. was formerly known as ZRC Services Inc. DBA ZiroC)

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TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient:

TWCC #:

MDR Tracking #:

IRO #:

M5-05-2257-01

5251

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

IRO America 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; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed provider, board certified and specialized in Chiropractic care. The reviewer is on the TWCC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who 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 IRO America 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(s) including: MDR rational by Sicem/Wendy Lee Therapy, Medical record review from Dorothy Leong, MD, Work Hardening notes from Maximum Therapeutic Initiative, LLC. FCE dated 8/17/2004, letter of medical necessity for neuromuscular stimulator, Operative report from Methodist Ambulatory Surgery Hospital-Northwest dated 6/16/2003, upper extremity NCV from Orthopedic Pain Management, PA dated 6/30/2004, office notes from Michael Jones MD, MRI of Left Elbow dated 3/04/2004, Impairment Rating by Bruce Kinzy MD dated 3/17/2004, Psychological Evaluation from Lisara Rehab Center dated 12/29/2004.

CLINICAL HISTORY

Mr. Alvarado was injured at work on 6/03/2003 while cutting an A/C duct with a saw. He is employed as a duct installer. He stated his wrist was lacerated by the sheet metal and was seen by Texas Medical Clinic on 6/7/2003. He underwent surgical repair on 6/16/2003. He then participated in post-surgical rehab and an active rehab and work hardening program.

DISPUTED SERVICE (S)

Under dispute is the retrospective medical necessity of: 97001 Evaluation, 97112 Neuromuscular Re-education, 97113 Aquatic Therapy, 97110 Therapeutic Exercises, 97140 Manual Therapy Techniques, Group Therapeutic Procedures for dates of service 4/19/2004 thru 8/27/2004.

DETERMINATION / DECISION

The Reviewer agrees with the determination of the insurance carrier in this case.

RATIONALE / BASIS FOR DECISION

All of the services in dispute within the disputed time frame are unreasonable and unnecessary. Neuromuscular re-education, aquatic therapy, therapeutic exercises, and manual therapy techniques are redundant services since a post surgical, active rehab, and work hardening program were completed. The time frame in which the disputed services were performed, fall far outside the acceptable standards of care, according to the *Texas Workers' Compensation Upper Extremity Treatment Guideline §134.1002*. Most guidelines, particularly those of the *Quality Assurance and Practice Parameters*, would support that no treatment is recommended for chronic condition to prevent the deleterious onset of physician dependence, somatization, continued chronicity, illness behavior, and de-conditioning all of which are adverse and lead to over utilization.

Screening Criteria

1. Texas Workers' Compensation Upper Extremity Treatment Guideline §134.1002
2. Quality Assurance and Practice Parameters

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

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

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

IRO America 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,

IRO America Inc.



Dr. Roger Glenn Brown

President & Chief Resolutions Officer