



Texas Department of Insurance, Division of Workers' Compensation
 7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION
Retrospective Medical Necessity

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestor's Name and Address: Advantage Healthcare 510 W. Davis St Dallas, TX 75208	MDR Tracking No.: M5-07-0592-01
	Previous Tracking No.: M4-06-4149-01
	Claim No.:
Respondent's Name and Address: Box 03	Injured Employee's Name:
	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "The carrier in the first denial stated the EMG was unnecessary medical. Yet the EMG was used in the final medical analysis of this patient."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary (Table of Disputed Services): "Claimant rec'd 0% IR and was released from care. This testing was not necessary. In addition, it does not appear to have been ordered by the treating doctor."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOB's

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
2-21-05	95903, 95904, 95860, 95934, 99242, A4215, A4556	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Total Due		\$0.00

PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution 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. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d) and 413.031
28 Texas Administrative Code Sec, 133.308 and 134.1

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the Requestor is not entitled to reimbursement of the IRO fee and is not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

_____	_____	03-29-07
Authorized Signature	Typed Name	Date of Findings and Decision

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

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

ZRC MEDICAL RESOLUTIONS

SENT TO: Texas Department of Insurance
Health & Workers' Compensation Network Certification & QA
Division (HWCN) MC 103-5A
Fax: 512.804.4868

01/30/07

RE: IRO Case #: M5.07.0592.01
Name: _____
Coverage Type: Workers' Compensation Health Care - Non- network
Type of Review:
 Preauthorization
 Concurrent Review
 Retrospective Review
Prevailing Party:
 Requestor
 Carrier

ZRC Medical Resolutions, Inc. (ZRC) has been certified, IRO Certificate #5340, by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to ZRC for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

ZRC has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, ZRC reviewed the medical records and documentation provided to ZRC by involved parties.

This case was reviewed by an MD with board certification in Neurology. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), and any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of ZRC, I certify that:

1. there is no known conflict between the reviewer, ZRC and/or any officer/employee of ZRC with any person or entity that is a party to the dispute, and

2. a copy of this IRO decision was sent to all of the parties via U.S. Postal service or otherwise transmitted in the manner indicated above on 01/30/07.

RIGHT TO APPEAL:

You have the right to appeal the decision by seeking judicial review. This IRO decision is binding during the appeal process.

For disputes other than those related to prospective or concurrent review of spinal surgery, the appeal must be filed:

1. directly with a district court in Travis County (see Labor Code 413.031(m)), and
2. within thirty (30) days after the date on which the decision is received by the appealing party.

For disputes related to prospective or concurrent review of spinal surgery, you may appeal the IRO decision by requesting a Contested Case Hearing (CCH). A request for CCH must be in writing and received by the Division of the Workers' Compensation, Division Chief Clerk, within ten (10) days of your receipt of this decision.

Sincerely,

Jeff Cunningham, D.C.
President/CEO

**REVIEWER REPORT
M5.07.0592.01**

DATE OF REVIEW: 01/29/07

IRO CASE #: M5 07 0592 01

DESCRIPTION OR THE SERVICE OF SERVICES IN DISPUTE:

Electro diagnostic studies performed on 2/21/2005

DESCRIPTION OF QUALIFICATIONS:

MD with board certification in neurology (special competence in child neurology) and in pediatrics

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

29 pages including the disputed electro diagnostic tests and previous medical reviews of the case.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

56 y/o male injured at work in ___ while lifting a heavy object (person) and suffering a lower back injury. His past medical history was positive for two prior back injuries. He was subsequently treated symptomatically with a return to work, an evaluation that concluded he was eligible for full duty, and participation in a work-hardening program, His level of impairment as of August 2004 was 0%. A further review later that year revealed some low-back tenderness, with further evaluation including an MRI indicating multiple changes suggestive of degenerative disk disease (degenerative joint disease) and no findings supportive of a surgical intervention or marked disability through pain. A second impairment rating of 0% was obtained from another physician in January 2005. Again, symptomatic measures were suggested. Upon consultation with a new care provider in February 2005, multiple physical signs were elicited. There was no weakness or any definitive sensory signs. Both nerve conduction and electromyography studies were ordered, followed by chiropractic manipulation and steroid injections. A third impairment rating in March 2005 returned at 5%. The basis of this final impairment is unknown. The EMG studies were entirely normal. The NCV studies reportedly showed mild right tibial and left peroneal prolongation.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

The MRI performed in 2004 implies a degenerative joint disease process as the underlying problem, with multiple back injuries over the years in that context. From the MRI study there appeared to be no reason for surgical intervention. In addition, the patient appeared to have recovered from the ___ injury with two maximal medical improvement assessments and impairment ratings of 0%. It is uncertain what led the patient to seek another medical consultation in January/February 2005, whether pain/limitation of activity or secondary emotional issues, but the examination in February 2005 appeared to be sufficiently equivocal that ordering electro diagnostic tests at that time and further MRI studies was unwarranted. Without physical findings of weakness to suggest any definitive spinal pathology leading to nerve impingement or impairment, ordering the EMG (with associated nerve conduction velocities) is not warranted. In addition, sensory nerve conduction velocities are of no value in evaluating sensory radiculopathy (see reference).

Given the known MRI findings and prior diagnosis of degenerative joint disease, the optimal treatment should have been therapies directed toward reduction of DJD. Further electro diagnostic testing in the context of no motor weakness (objective findings) was inappropriate.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

- ACOEM Knowledgebase
- AHCPR - Agency for Healthcare Research & Quality Guidelines
- DWC - Division of Workers' Compensation Policies or Guidelines
- European Guidelines for Management of Chronic Low Back Pain
- Interqual Criteria
- Medical judgment, clinical experience and expertise in accordance with accepted Medical standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG - Official Disability Guidelines & Treatment Guidelines
- Pressley Reed, The Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters
- Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer-reviewed, nationally accepted medical literature (with description)
- Other evidence-based, scientifically valid, outcome-focused guidelines (with description): Electro diagnostic testing of nerves and muscles: When, why, and how to order K. Chemali, B. Tsao; CLEVELAND CLINIC JOURNAL OF MEDICINE, 72:1, JANUARY 2005,37-49