

Z iro C

A Division of ZRC Services, Inc.

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May 12, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient:

TWCC #:

MDR Tracking #: M2-05-1401-01

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 care. 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

Request for 4 weeks of Work Hardening, Impairment Rating from John Hodges DC, notes from HealthPartners-chronic pain management, FCE from Optimum, MRI of Left Ankle, lower extremity EMG, Radiology records from UT-Galveston, office notes from John Hodges DC, notes from Keith Pinchot MD, notes from Nahas Medical service, notes from Ranjit Patel MD, review determination from UniMed Direct, notes from Christus St. John Hospital, RME from David Vanderweide MD, notes from Crosspoint Medical Center.

CLINICAL HISTORY

This patient was involved in an on the job injury _____. She stated to the treating doctor that while she was walking and conversing with a customer, she turned to go behind her work counter to

perform a job task. The patient went on to say that she continued her conversation and maintained eye contact with the customer as she went around the counter. As she rounded the counter she tripped over two Marine batteries, falling forward and to the left. She grabbed the counter with her left arm/shoulder, twisting her back and neck in the process. She did not fall all the way to the floor. She worked the rest of her shift as her ankle began to swell. She stated that the batteries did not belong there and did not know who put them there. She stated that she presented to the hospital on 3/17/03 due to continued pain and swelling.

REQUESTED SERVICE

Work Hardening for 4 weeks/ 6 hours a day, for 5 days a week is requested for this patient.

DECISION

The reviewer agrees with the determination of the insurance carrier.

BASIS FOR THE DECISION

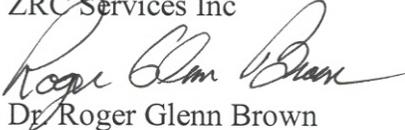
The diagnosis given to the ankle by the treating doctor is an 845.0, left ankle sprain, according to the International Classification of Diseases, 9th edition. According to all definitions and treatment guidelines, this is a self-limiting diagnosis. Using the Lower Extremity Treatment Guideline published by the Texas Workers' Compensation Commission §134.1003, this diagnosis, for all levels of care, primary, secondary and tertiary, show the duration to be 0-2 months. In some cases there are times where depending on the severity of the tear, the healing and treatment time may extend slightly beyond the stated duration. With the stated diagnosis, there is a limited time of treatment and an aggressive approach is best suited for adequate recovery. The request for 4 weeks of work hardening was made on January 26, 2005. This is nearly two years post injury and very close to statutory MMI. In the Reviewer's opinion, this is not reasonable to expect a positive outcome or medically necessary due to no documentation for a possible surgical consultation based on persistent failure to respond to nonoperative/operative treatment. This request also falls outside the treatment time given by the Mercy Guidelines. The records that were submitted did not show any objective functional improvement or reflect a progression towards a self-directed care type program/home exercise program. In reference to the American College of Occupational & Environmental Medicine Guideline, pg40, "evidence of objective functional improvement is essential to establish a reasonableness and necessity of care, progression towards a self-directed care type program/home exercise program, and maximizing activity tolerance are best practices to reduce somatization and physician dependency". Return to full duty work may not always be possible and may necessitate the introduction of vocational rehabilitation services by referral to the Texas Rehabilitation Commission.

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 and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,
ZRC Services Inc



Dr. Roger Glenn Brown
Chairman & CEO

Cc: John Hodges, DC
Fax 281-332-8192

American Home Assurance
Fax 479-273-8792

YOUR RIGHT TO REQUEST A HEARING

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

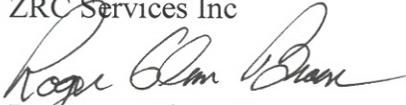
The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

Name/signature

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this _____ day of _____, 2005.

Name and Signature of Ziroc Representative:

Sincerely,
ZRC Services Inc

A handwritten signature in cursive script, appearing to read "Roger Glenn Brown".

Dr. Roger Glenn Brown
Chairman & CEO