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A Division of ZRC Services, Inc.

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June 29, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: _____

TWCC #: _____

MDR Tracking #: M2-05-1853-01

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 MD board certified and specialized in Orthopedic Surgery

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

Notification of IRO assignment, information provided by Requestor, Respondent, and Treating Doctor including:

1. Office note, Pain Management Dr. Carrasco, 01/17/05, 03/10/05
2. Consent for functional capacity evaluation, 02/01/05
3. Peer review analysis, 03/18/05 and 04/06/05
4. Liberty Mutual letter notification of denial, 03/18/05, 04/06/05
5. Appeal letter, Dr. Carrasco, 04/04/05
6. Liberty Mutual letter to Texas WC, 05/31/04

CLINICAL HISTORY

This claimant is a 49-year-old female with an ongoing complaint of left hand and wrist pain with intermittent numbness and tingling. The date of onset of symptoms was noted to be _____. In a clinical note from 01/17/05, Dr. Carrasco noted myofascial tenderness to the right extensor carpal radialis longus, the right extensor carpal radialis brevis, the right and left pronator, and the left brachial radialis. Sensation was intact, and there was noted hyperhidrosis bilaterally. The claimant had been treated with oral corticosteroid, therapy and trigger point injections with some relief. The request is for a series of Botox chemodenervation injections with EMG guidance.

DISPUTED SERVICE(S)

Under dispute is the prospective or concurrent medical necessity of proposed destruction, cervical spinal muscles, with neurolytic agent.

DETERMINATION/DECISION

The Reviewer agrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

It appears from this medical record that the claimant has complaints of left arm and hand pain. The medical record is silent on specific objective physical abnormalities such as loss of motion, weakness, reflex change, or sensation change. The claimant does complain of some tenderness of both upper extremities but there were no objective physical findings to correlate with her subjective complaints. There is no objective abnormal testing such as an EMG or MRI and her treating physician has asked for authorization to do Botox injections in an attempt to decrease her complaints. While there are a number of different diagnoses listed for this claimant by her treating physician, there is no indication based on these medical records that the claimant has reflex sympathetic dystrophy, neurologic deficit, or any clear objective loss of function or abnormality. Based on the lack of clear objective abnormal physical findings and a review of the literature in terms of Botox treatment in patients with chronic pain complaints, there does not appear to be any medical indication or necessity for the proposed destruction of a cervical spinal muscle with a neurologic agent, Botox, in this claimant.

Screening Criteria

1. Specific: AAOS, Orthopedic Knowledge Update 7, Koval, editor, page 221. Campbell's Operative Orthopedics, Volume 4, page 3670
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.

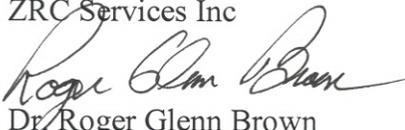
CERTIFICATION BY OFFICER

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 or facsimile, a copy of this finding to the TWCC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,
ZRC Services Inc



Dr Roger Glenn Brown
Chairman & CEO

Cc: [Carrier]

Liberty Ins. Corp.
Melissa Rodriguez
Fax 512-231-0210

A.T. Carrasco
Fax 210-614-4525

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

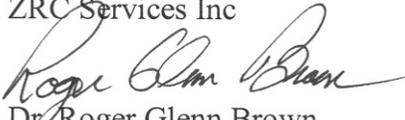
The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

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 29th day of June 2005.

Name and Signature of Ziroc Representative:

Sincerely,
ZRC Services Inc



Dr. Roger Glenn Brown
Chairman & CEO