

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor Allied Multicare Centers 415 Lake Air Dr. Waco, TX 76710	MDR Tracking No.: M5-05-0269-01
	TWCC No.:
	Injured Employee's Name:
Respondent's American Casualty Co. Rep. Box # 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: MEDICAL NECESSITY DISPUTE

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 9-17-04.

Dates of service 9-12-03 and 9-15-03 were submitted untimely per Rule 133.308 and will not be considered further due to lack of jurisdiction.

The dispute did not contain EOBs for all of the dates in service; however, both parties in the dispute submitted a table that listed all of the disputed services and indicated that initial denial code was "U." Therefore, a dispute does not exist over basis of denial of disputed services. The reconsideration EOBs indicated that denial of payment was based upon, "O – Denial after reconsideration." The respondent also included denial code "R – Extent of Injury" as a basis for denial for dates of service, 10-6-03 through 10-10-03. A TWCC21 report was not filed with the Commission disputing the extent of injury; therefore, services will be reviewed based upon medical necessity.

The IRO report dated 11-15-04 noted, "The reviewer disagrees with the prior adverse determination regarding care through 12/3/03, as the care rendered through this date is deemed medically necessary and appropriate. All care past 12/3/03 is not deemed medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees (\$2,711.54). Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

Ordered by:

Elizabeth Pickle, RHIA

May 5, 2005

Authorized Signature

Typed Name

Date of Order

PART V: 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 it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) 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 Representatives 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.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

November 15, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

Patient:
TWCC #:
MDR Tracking #: M5-05-0269-01
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 Doctor of 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

Records available for review included the attorney's letter, emergency medical records from Providence Health Center, Electrodiagnostic test report by Roger Harman, M.D., Comprehensive Medial Analysis form Derek Martin, D.C., MRI report, RME report from Don Mackey M.D., Impairment report, office notes/reports from Dr. Linderman from 08/23/03 through 03/22/04.

CLINICAL HISTORY

This patient was initially injured on ___ when she backed up and tripped over a box on the floor, injuring her left hip and sacroiliac joint.

DISPUTED SERVICES

Under dispute is the medical necessity of manipulations, therapeutic procedures, therapeutic activities and modalities from 09/12/03 through 03/22/04.

DECISION

The reviewer disagrees with the prior adverse determination regarding care through 12/03/03, as the care rendered through this date is deemed medically necessary and appropriate. All care past 12/03/03 is not deemed medically necessary.

BASIS FOR THE DECISION

This patient had examination evaluations on 08/27/03, 09/26/03, 10/31/03 and 12/03/03. All these exams showed objective and subjective improvement. On the 12/3/03 examination the patient's VAS was a 1 on a 0-10 scale, range of motion of the hip and lower back were found to be normal. The patient had approximately 23 visits up to the 12/03/03 examination. Medicare guidelines for the Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal disease and/or injuries (Medicare Newsletter March 14, 2003 from Trailblazer Health Enterprises, LLC) allow for 18 sessions of physical medicine and then documentation supporting medical necessity of continuing treatment. The additional supporting documentation in this case would allow for care up to 12/03/03.

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 this finding by US Postal Service to the TWCC.

Sincerely,

Nan Cunningham
President/CEO

CC: Ziroc Medical Director