

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-1687-01
Name of Patient: _____	
Name of URA/Payer:	American Home Assurance
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Rogelio Rodriguez, DC

July 24, 2006

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
Rogelio Rodriguez, DC
Division of Workers' Compensation

DOCUMENTS REVIEWED

1. Notification of IRO Assignment and Table of Disputed Services
2. Carrier denials, dated 5/26/06 and 6/16/06
3. Treating doctor initial preauthorization request, dated 5/23/06, and request for reconsideration, dated 6/9/06
4. Treating doctor's statement of position, dated 7/13/06
5. Treating doctor's initial report, dated 5/1/06
6. Treating doctor's subsequent reports, dated 5/11/06 and 5/17/06
7. MRI reports, left shoulder, right knee and lumbar spine, dated 5/12/06
8. Radiographic reports, right knee and left shoulder, dated 5/12/06
9. Medical consultation report, dated 5/17/06, and follow-up note dated 6/21/06
10. Orthopedic consultation report, dated 5/31/06
11. Treating doctor's "physical medicine documentation," multiple dates
12. Employee's First Report of Injury/Illness, dated 5/3/06
13. Various TWCC-73s

CLINICAL HISTORY

Patient is a 39-year-old female employee of a large discount department store who, on ___, was walking from the warehouse to the shoe department when she slipped on some water and fell, landing onto her right knee, lower back, left thigh, and with her left upper extremity outstretched, jamming her left shoulder. She reportedly also hit her head on the floor, causing head and neck pain. She was initially seen at a local hospital, where only a urine test was performed. On 5/1/06, she presented to a doctor of chiropractic for conservative care, including physical therapy and rehabilitation. The claimant was also referred to an orthopedist for evaluation of her left shoulder and right knee, and to a medical doctor for medications. Epidural steroid injections were requested for the lower back, but were not approved.

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REQUESTED SERVICE(S)

Pre-authorization for physical therapy 3 x 4, consisting of therapeutic exercises (97110) and manual therapy techniques (97140).

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. With documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains.

The medical records submitted in this case sufficiently documented that a compensable injury occurred to multiple areas when this claimant fell on _____. The records also adequately establish that it is medically necessary that the patient participate in a supervised program of therapeutic activities, and a regimen of manual therapy techniques. In addition, the treatment rendered thus far has fulfilled the statutory requirements¹ for medical necessity, since the patient has obtained relief and promotion of recovery was accomplished since the patient's range of motion improved between the two evaluations dates. Moreover, the carrier used—as its basis for denial—that that the patient had already participated in “over 50 sessions of supervised PT,” and “completion of tertiary CPMP.” In reality, however, they were using the wrong claim number and injury date in their citation. Therefore, since their denial was based on incorrect data, they lacked sufficient basis to deny this treatment.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and the injured

¹ Texas Labor Code 408.021

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employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

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

In accordance with Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 25th day of July 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell