

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-1734-01
Name of Patient:	_____
Name of URA/Payer:	TX Municipal League
Name of Provider: (ER, Hospital, or Other Facility)	Edinburg Physical Med. & Rehab
Name of Physician: (Treating or Requesting)	Monzer Yazji, MD

August 31, 2006

An independent review of the above-referenced case has been completed by a physician (board certified) in family practice. 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.

August 31, 2006
Notice of Independent Review Determination
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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
Edinburg Physical Med & Rehab
Monzer Yazji, MD
Division of Workers' Compensation

RE: ____

DOCUMENTS REVIEWED

1. Paperwork from Edinburg Physical Medicine and Rehab
2. Denial letters for Corvel
3. TWCC forms including TWCC-69 dated 11/28/05
4. Letters from Scott Bouton, lawyer
5. Reports on MRI L-S Spine 5/9/05 and 5/20/06
6. Office notes from Dr. Yazji
7. RME by Dr. Lopez on 6/1/05
8. Note from Dr. Stehr, DC; dated 5/12/06
9. Electrodiagnostic studies per Dr. Khabbaze on 6/6/05
10. Consultation letter from Dr. Marquez on 7/12/05

CLINICAL HISTORY

Ms. ____ sustained a work related back injury on _____. She was treated with medications, physical therapy, and rest. She also apparently had chiropractic care and ESI per Dr. Rashid. An RME by Dr. Lopez on 6/1/05 stated her injuries from the fall had resolved and current symptoms are not from her compensable injury on 3/01/05. The TWCC-69 form per Dr. Yazji on 11/28/05 document her lumbar strain had reached MMI on 11/28/05 with a 5% impairment rating. She had returned to work with no restrictions. The records reflect the patient followed up in May 2006, for symptoms that started one month earlier. Physical therapy was requested and denied. An appeal upheld the prior decision.

REQUESTED SERVICE(S)

Physical therapy to include CPT codes: 97110, G0238, 97010, 97124.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Ms. ____ original injury of a lumbar strain/sprain was treated appropriately and thoroughly. An RME on 6/1/05 documents that her symptoms are no longer from her compensable injury. Also, TWCC-69 form by Dr. Yazji on 11/28/05 documents MMI with a 5% impairment rating. Symptoms arising in April 2006, are certainly no longer related to her compensable injury from _____, which was a lumbar

RE: ____

strain/sprain. According to standard textbooks and generally accepted guidelines like CMS and ACOEM, lumbar strain is typically treated conservatively for 2-3 months. Symptoms arising 13 months after the original injury cannot be attributed to a lumbar strain from 3/01/05. Therefore, the requested services are not certified and the initial decision is upheld.

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 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 31st day of August 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell