

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71

Phone: 512-288-3300

Austin, Texas 78735

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-07-0249-01
Name of Patient:	_____
Name of URA/Payer:	Discovery Property and Casualty
Name of Provider: (ER, Hospital, or Other Facility)	Efrem L. Castillo, MD
Name of Physician: (Treating or Requesting)	Efrem L. Castillo, MD

December 6, 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.

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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
Efreml. Castillo, MD
Division of Workers' Compensation

RE: ____

DOCUMENTS REVIEWED

1. Denial letter from JI Specialty Services, Inc. dated 07-26-06.
2. Ryke Physical Therapy progress notes
3. Clinical notes from Dr. Castillo
4. A RME per Dr. Williams from 03-08-06
5. Denial letter from Dr. Cynthia Tays on 10-17-06
6. Denial letter from Dr. Reznick dated 07-06-06
7. MRI report of the C-Spine dated 03-01-06
8. Progress note on 11-03-06 from Dr. Parra

CLINICAL HISTORY

Mr. ____ sustained injuries on _____. The enclosed records provided for review primarily address neck and shoulder issues. Ankle symptoms are sporadically mentioned in a cursory way.

REQUESTED SERVICE(S)

OP PT 3WK X WK X 2 WKS to left ankle

DECISION

Denied

RATIONALE/BASIS FOR DECISION

Considering the date from the original injuries, no correlation can be made from the patient's ankle symptoms over 3 ½ years later. The patient appears to have a simple ankle sprain. Symptoms typically resolve after 6-8 weeks of conservative treatment. This viewpoint is supported by ACOEM guidelines, standard textbooks and generally accepted peer review literature. No records submitted portray a complicated ankle injury. No x-ray or MRI of the ankle was forwarded for review. Therefore, no justification is supported for physical therapy on an ankle sprain over 3 years out from the date of the injury.

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RE: _____

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 6th day of December, 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell