

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-07-0613-01
Name of Patient:	
Name of URA/Payer:	Assoc. Casualty Insurance Co.
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Korey Kothmann, DC

February 2, 2007

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: _____
Korey Kothmann, DC
Division of Workers' Compensation

RE: ____

DOCUMENTS REVIEWED

- Denial letters from Corvel
- Dr. Kothmann's clinical notes including an impairment rating dated 2/21/05

CLINICAL HISTORY

Ms. ____ sustained a compensable injury on _____. One document states a hyperextension injury to both wrists due to falling on the handles of a trash cart while another states it was a MVA. Apparently she was initially treated only on her right wrist and had physical therapy, chiropractic care from Dr. Scott Howard and eventually surgery (no records enclosed). On 8/3/06 Worker's Compensation approved treatment for her left wrist with Carpal Tunnel Syndrome. Of note is an Impairment Rating done on 2/21/05 stating the patient had no left wrist symptom. Dr. Kothmann, DC, initiated treatment on 8/22/05 and stated the patient's prognosis as good. A follow-up on 9/1/05 states her prognosis is now fair. A request for physical therapy was denied on 11/16/06 and an appeal was denied as well on 11/27/06.

REQUESTED SERVICE(S)

Physical Therapy – 12 sessions

DECISION

Uphold previous denial.

RATIONALE/BASIS FOR DECISION

The documentation submitted had several inconsistencies including mechanism of injury. The date of injury was ____ then a note on 2/21/05 states she has no left wrist symptoms then she has symptoms and seeks treatment on 8/22/06. There is no documentation enclosed of conservative treatment including ice packs, splints, and anti-inflammatory medications. No x-ray reports or EMB/NCS were submitted for review. Finally, physical therapy cannot be medically justified for an injury from 5/19/04 that was diagnosed as a sprain and CTS and still having symptoms over 2 ½ years after the original injury. Physical therapy at this point would not improve function, decrease symptoms, or change the patient's work status. This view is

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RE: _____

supported by peer reviewed literature, standard textbooks, and generally accepted guidelines like CMS and ACOEM. Therefore, the prior denial 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 2nd day of February, 2007.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell