

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

SENT TO: Texas Department of Insurance  
Health & Workers' Compensation Network Certification and QA Division (HWCN)  
MC 103-5A  
Via E-mail [IRODecisions@tdi.state.tx.us](mailto:IRODecisions@tdi.state.tx.us)

RE: IRO Case #:  
Name:  
Coverage Type:

Type of Review:

- Preauthorization or Concurrent Review  
 Retrospective Review

Parker Healthcare Management Organization, Inc. has been certified, certification number, by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to the IRO for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

The IRO has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, the IRO reviewed the medical records and documentation provided to the IRO by involved parties.

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of Parker Healthcare Management Organization, Inc. I certify that:

1. there is no known conflict between the reviewer, the IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute, and
2. a copy of this IRO decision was sent to all of the parties via U.S. Postal Service or otherwise transmitted in the manner indicated above on March 20, 2007.

#### Right to Appeal

You have the right to appeal the decision by seeking judicial review. The decision of the IRO is binding during the appeal process.

For disputes *other than* those related to prospective or concurrent review of spinal surgery the appeal must be filed:

- 1) directly with a district court in Travis County (see Labor Code §413.031(m), and
- 2) within thirty (30) days after the date on which the decision is received by the appealing party.

For disputes related to *prospective or concurrent review of spinal surgery*, you may appeal the IRO decision by requesting a Contested Case Hearing (CCH). A request for a CCH must be in writing and received by the Division of the Workers' Compensation, Division Chief Clerk, within ten (10) days of your receipt of this decision.

Sincerely,

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**DATE OF REVIEW:**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Medical necessity of Lumbar Fusion at L5-S1

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.4	63047; 22612; 22630; 22842; 20936		Prosp	1			10.30.06	20061056566001NE	Upheld
724.4	27299; 22851; 20938; 38230; 20974; L0310			1				20061056566001NE	Upheld

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

TDI-HWCN-Request for an IRO

Respondent records- a total of 49 pages of records received to include but not limited to:

- CMS letter, 3.2.07; Review, 2.12.07, 2.13.07, 2.19.07; Records, Dr., 2.8.07- 2.13.07 ; MRI Lumbar, 11.15.06; Patient notes, Dr., 12.27.06; CT Lumbar, 1.23.07; letter, 2.13.07, 2.20.07; X-Rays, 2.8.07

Requestor records- a total of 5 pages of records received to include but not limited to:

- Records, Dr., 2.8.07- 2.20.07, X-Rays, 2.8.07

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient sustained a work related on the job injury on, while employed with.

## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

The patient had a work incident with. She had a neurosurgical evaluation by Dr. on 12.27.06 without noted neurological deficit. He did not recommend any surgery. The workup included a lumbar MRI on 11.15.06, which showed a 3-4 mm L5-S1 disc protrusion centrally and a 1-2 mm disc bulge with mild to moderate facet disease at L4-5. The subsequent 1.23.07 lumbar CT scan showed the L5 level to have pars deficits. The 2.8.07 lumbar myelogram/CT scan noted a small central disc protrusion ( 3 mm) at L5-S1 with pars deficits. The myelogram showed no root sleeve displacement. There was noted L4-5 facet arthrosis. There were flexion/extension radiographs but the amount of displacement was not quantified. Dr. alleged pending cauda equina symptoms lack imaging validation nor has there been further testing of her urological dysfunction. The L5-S1 spondylolisthesis was a pre-existing condition. Thus, the medical necessity for a L5-S1 fusion is not validated by these records.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA

**XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES

**XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL

**XX PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE**  
*Spine Instructional Course Lectures, 2003, American Academy Orthopedic Surgeons.*

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)