

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** OCTOBER 6, 2008

**IRO CASE #:**

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

Medical necessity of proposed outpatient work hardening daily, 5 X week X 4 weeks

### **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 Physical medicine and Rehabilitation, 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) (Disagree)
- 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
847.0, 847.1	97545		Prosp	20					Overturned
847.0, 847.1	97546		Prosp	40					Overturned

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient was a xx-year-old male injured on xx/xx/xx after injury at work to his cervical spine. He felt a pop in his neck doing his routine work activities and had severe pain. The patient underwent surgery to the cervical spine on March 17, 2008. He had pre and postoperative therapy. He underwent a comprehensive functional capacity evaluation. The reviewer denied the services, indicating that the functional capacity was for psychological and not physiologic problems.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

This individual has a set work restriction and therefore a job capacity, he is employable at his restriction level. He meets the ODG criteria and the medical need of functional restoration post Cervical spine Surgery with a disc sparing procedure. Therefore, the requested work hardening program is medically necessary.

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

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

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES