

Parker Healthcare Management Organization, Inc.

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972.906.0603 972.255.9712 (fax)

Certificate # 5301

June 1, 2005

ATTN: Program Administrator
Texas Workers Compensation Commission
Medical Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M2-05-1206-01
RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 3.21.05.
- Fax request for provider records made on 3.22.05.
- Order for Payment issued by TWCC on 4.8.05.
- Order for Production of Records from respondent issued from TWCC on 4.27.05.
- The case was assigned to a reviewer on 5.13.05.
- The reviewer rendered a determination on 5.31.05.
- The Notice of Determination was sent on 6.1.05.

The findings of the independent review are as follows:

Summary of Clinical History

Mr. ____ sustained multiple levels of cervical disc injuries due to a work related injury that occurred on ____.

Questions for Review

Medical necessity of the proposed work hardening program, 5X week for 2 weeks

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **uphold the denial**.

Clinical Rationale

Mr. ___ had a 3.5.03 neck injury that was subsequently treated with a 4 level disc excision and fusion from C3 to C7 on 11.10.03. The patient has already undergone work hardening and achieved the medium heavy PDL. His prior work requirement was heavy PDL.

With Mr. ___'s multiple level cervical spine surgery and fusion, he is at increased risk for adjacent level breakdown (transition zone). He warrants permanent restrictions to limit his lifting versus further work hardening to bring him to a higher level of lifting capability.

Thus, there is no medical necessity in an attempt to bring Mr. ___ to a heavy PDL, when this PDL is not physiologically consistent long-term with his postoperative four-level cervical spine fusion.

This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced, or for a specific course of action to be taken by a third party. Medicine is both an art and a science and although the individual may appear to be fit to participate in various types of activities, there is no guarantee that the individual will not be re-injured, or suffer additional injury as a result of participating in certain types of activities.

Clinical Criteria, Utilization Guidelines or other material referenced

- Spine Institutional Course Lectures
- American Academy of Orthopedic Surgeons 2003

This conclusion is supported by the reviewers' clinical experience with over 15 years of patient care and orthopedic surgery.

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is a diplomate of the American Board of Orthopedic Surgery, and is engaged in the full time practice of medicine.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of

Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceeding/Appeals , P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request. The party appealing the Division's Decision shall deliver a copy of this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department, the requestor (if different from the patient) and the respondent. I hereby verify that a copy of this Findings and Decision was mailed to the injured worker (the requestor) applicable to Commission Rule 102.5 this 1st day of June, 2005. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

Meredith Thomas, IRO Administrator

CC:

Nestor Martinez, DC
Attn: Gracie Diaz
Fax: 713.697.7111

Zurich Ins. c/o FOL
Attn: Annette Moffett
Fax: 512.867.1733

[Claimant]