

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Road, Irving, TX 75038

972.906.0603 972.255.9712 (fax)

Certificate # 5301

June 2, 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: M2-05-1270-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 4.1.05.
- Faxed request for provider records made on 4.1.05.
- Order for Payment was issued by TWCC on 5.5.05.
- Order for Production of Records was issued by TWCC on 5.12.05.
- The case was assigned to a reviewer on 5.20.05.
- The reviewer rendered a determination on 5.31.05.
- The Notice of Determination was sent on 6.2.05.

The findings of the independent review are as follows:

Questions for Review

Prospective medical necessity of 2 weeks of work conditioning for 4 hours per day; 3 to 5 days per week

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 **overturn the denial**.

Summary of Clinical History

Ms. ____ sustained a work related injury on ____, while she was employed with Walgreen's. She reported to have twisted her left knee while lifting material off of a truck. Since then, the patient has received therapy, medical intervention and diagnostics to improve her condition.

Clinical Rationale

Ms. ___ has received functional studies that demonstrate she is not capable of returning back to work at her current FCE performance level for the required PDL that she must meet in order to do her job safely and accurately. On 12.6.2004, Ms. ___ was evaluated by Dr. George Armstrong, Orthopedic surgeon, who agreed with the treating provider that a work hardening program was necessary in the patient's recovery.

Dr. Wayne Soignier, M.D., Disability Determination Officer for TWCC reported on a MMI evaluation 3.16.05, that the patient demonstrated some abnormal COV findings and thus deemed the patient inconsistent. He stated that the patient is either malingering, lacking in effort, has somatoform disorder or self limits secondary to pain. Dr. Soignier stated this without demonstrating which COV's were abnormal and by what percentages they were abnormal. He also did not reveal what other legitimate causes that may create a situation in which the patient performs less than adequate, such as pain and injury, which is documented throughout the records as being present.

The patient should receive the tertiary therapy in order to be offered the opportunity to function at the highest possible PDL or the PDL necessary to do her job. The trial period of tertiary care, which is two weeks of work conditioning, is optimal to see if this type of therapy will have an impact on her return to work goals.

Clinical Criteria, Utilization Guidelines or other material referenced

Occupational Medicine Practice Guidelines, Second Edition.

The Medical Disability Advisor, Presley Reed MD

A Doctors Guide to Record Keeping, Utilization Management and Review, Gregg Fisher

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

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 2nd 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:

Forward Health Solutions
Attn: Alicia Marquez
Fax: 888.211.3808

Broadspire
Attn: Pam Greer
Fax: 972.250.5002

[Claimant]