

Parker Healthcare Management Organization, Inc.

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Certificate # 5301

July 18, 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: M2-05-1849-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 6.8.05.
- Faxed request for provider records made on 6.8.05.
- TWCC issued an Order for records 6.24.05.
- The case was assigned to a reviewer on 7.8.05.
- The reviewer rendered a determination on 7.15.05.
- The Notice of Determination was sent on 7.18.05.

The findings of the independent review are as follows:

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**.

Questions for Review

Prospective medical necessity of work conditioning.

Summary of Clinical History

____ was riding on the back of a truck when the truck hit a bump and struck his tailbone forcibly on the truck. He has had coccyx pain since that time. He has been treated by his physician, Dr. Ruibal. He is 6 months post injury and still has complaints of pain.

Clinical Rationale

The records reviewed reflect that the carrier initially denied this service stating that the patient had symptom magnification and that SV did not have numbers provided for criteria to meet validity. The SV

was performed using the Blankenship method, a well respected, state-of-the-art method, and numbers were provided, so I disagree with the carrier's conclusion. Furthermore and more importantly, the carrier denied work conditioning, as a contusion of the coccyx is not an entity that would require work conditioning and, despite pain, it would neither cure nor treat the condition.

In reviewing the claimant's notes from his physician, the only diagnosis listed is contusion of the coccyx. There is no other evidence of injury of radiculopathy, sprain, strain, or other injury to the back. While imaging studies showed a normal sacral MRI and a bulging disc, there was no evidence of abnormality.

The request for work conditioning for contusion of the coccyx is not warranted or consistent with standards or norms of treatment with coccyx contusions. These are treated as outlined in the carrier's report with possible sitz baths, analgesics, and a cushion. Only time will cure these injuries and there is no benefit or role of work conditioning, despite the fact that an SVU was performed, showing that he is not at job level. The reasons for him not being at job level are unclear and could be related to pain, but work conditioning would not reduce his pain.

This individual can likely perform some form of light duty and time may be the best and most appropriate treatment to see if his condition will resolve.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 10 years of patient care.

The reviewer for this case is 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.

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 18th day of July, 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
Administrator
Parker Healthcare Management Organization, Inc.

CC: Zurich N. America
Attn: Annette Moffett
Fax: 512.867.1733

[Claimant]