

Parker Healthcare Management Organization, Inc.

4030 N. Beltline Road, Irving, TX 75038

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Certificate # 5301

September 7, 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: M2-05-2140-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 8.2.05.
- Faxed request for provider records made on 8.2.05.
- TWCC issued an Order for Payment on 8.12.05.
- The case was assigned to a reviewer on 8.22.05.
- The reviewer rendered a determination on 9.6.05.
- The Notice of Determination was sent on 9.7.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of proposed IDET procedure.

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** on the requested service(s).

Summary of Clinical History

Mr. ____ is a 42-year-old male, who sustained injury to his lower back when he was straining to lift concrete material into a back hoe. He had developed severe pain in his lower back with radiation down the left leg all the way to the left calf. He was originally treated by Dr. Wang and eventually was referred to Dr. Kenneth Berliner. He has had considerable imaging workups which include MRI, myelograms, CT scan, discogram with CT scan. Dr. Berliner has requested an IDET procedure to be authorized, but this has been denied by the carrier. Dr. Berliner has requested a reconsideration of the denial and the carrier has again denied the IDET procedure.

Clinical Rationale

According to SAAL and SAAL in their 2000 paper, and SPINE, the IDET procedure is not indicated in multiple levels of degenerative disc problems. Mr. ___ has 3 levels of disc bulging and has some evidence reported of arachnoiditis and clumping with adhesions on the nerve roots at the L3-L4 level on his myelogram CT scan. He has complained of considerable left buttock pain radiating down the left leg all the way to the left calf. There was some foraminal stenosis was reported at L4-L5 on the MRI. For these reasons, he does not fit the criteria for the indications for IDET. I therefore agree with the carrier's denial of the IDET.

Clinical Criteria, Utilization Guidelines or other material referenced

- SAAL- 2000 report
- SAAL-200 report
- American Academy of Orthopedic Surgeons 2003

This conclusion is supported by the reviewers' clinical experience with over 10 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 diplomat 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 7th day of September, 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:

Kenneth Berliner, M.D.
Attn: Brenda Gonzalez
281.875.3285

TX Mutual Ins.
Attn: Letreace Giles
512.224.7094

[Claimant]