

# Parker Healthcare Management Organization, Inc.

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Certificate # 5301

October 12, 2005

**ATTN: Program Administrator**

**Texas Department of Insurance/Workers Compensation Division**

7551 Metro Center Drive, Suite 100

Austin, TX 78744

Delivered by fax: 512.804.4868

## Notice of Determination

MDR TRACKING NUMBER: M2-05-2283-01  
RE: Independent review for \_\_\_\_

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

- Parker Healthcare Management received notification of independent review on 9.14.05.
- Faxed request for provider records made on 9.14.05.
- The case was assigned to a reviewer on 10.03.05.
- The reviewer rendered a determination on 10.11.05.
- The Notice of Determination was sent on 10.12.05.

The findings of the independent review are as follows:

### Questions for Review

Medical necessity of an orthopedic mattress.

### 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

Records indicate that the patient was seen by neurosurgeon, David Dean, M.D. Dr. Dean notes that on May 2, 2005, the patient was very distraught and emotionally very labile. Mrs. \_\_\_\_ stated the patient had been depressed and frequently weeping. His mother-in-law, who had been hospitalized for some time, also recently passed. Dr. Dean indicated that medications were needed. He documented hypertension in his physical examination findings. On another note, he indicated that the patient weighs 240 pounds. He recommended that the patient take a leave of absence. The patient complains of pain in his right leg and knee and wants to get away for no reason at all. There is a prescription documented indicating an orthopedic mattress for diagnosis of cervical spondylosis, radiculopathy and lumbar spondylosis.

The post monogram CT of the cervical spine shows a prior ACDF (anterior cervical discectomy and fusion) at C5-6. CT monogram of the lumbar spine shows large, diffuse bulges with moderate to large facet and ligamentous hypertrophy at L1-L2. There were diffuse bulges at L2-3 that are moderate and the same with L3-4, all with ligamentous hypertrophy and moderate facet hypertrophy. At L4-5 there is a large diffuse, disk bulge with vacuum disc phenomenon. At L5-S1 there is a moderate to large diffuse disk bulge with vacuum disc phenomenon. This is noted on January 21, 2005 and indicates that the patient has lumbar spondylosis and degenerative disk disease. His pain may be lumbosacral radiculopathy.

## Clinical Rationale

It is determined to uphold the URA's denial of purchase of an orthopedic mattress for cervical spondylosis, radiculopathy, and lumbar spondylosis. Both of these conditions of spondylosis were likely pre-existing conditions. There is no literature to support that any particular type of mattress will have any treatment effect on these conditions. As a matter of fact, the literature is quite varied as to whether or not a firm or soft mattress is best. In short, the records indicate that a majority of the complaints are due to underlying degenerative changes and that treatment with a change of mattress would not be a result of any work injury. Therefore, it should not be considered a covered appliance.

## Clinical Criteria, Utilization Guidelines or other material referenced

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

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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 Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC'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, the injured employee, injured employee's insurance carrier, the URA or any 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 Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision. The address for the Chief Clerk of Proceedings would be: P.O. Box 17787, Austin, Texas, 78744.

I hereby verify that a copy of this Findings and Decision was faxed to the Texas Department of Insurance /Division of Workers Compensation, 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 12<sup>th</sup> day of October, 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.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.

CC: TML Intergovernmental Risk Pool/FOL  
Attn: Katie Foster  
Fax: 512.867.1733

[Claimant]