**Parker Healthcare Management Organization, Inc.**
3719 N. Beltline Road, Irving, TX 75038
972.906.0603 972.255.9712 (fax)
Certificate # 5301

June 27, 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: M2-05-1606-01
RE: Independent review for ___

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

- Parker Healthcare Management received notification of independent review on 5.11.05.
- Faxed request for provider records made on 5.11.05.
- TWCC issued an Order for Payment on 5.27.05.
- The case was assigned to a reviewer on 6.13.05.
- The reviewer rendered a determination on 6.24.05.
- The Notice of Determination was sent on 6.27.05.

The findings of the independent review are as follows:

## Questions for Review

Medical necessity of the proposed purchase of an RS4i muscle stimulator

## 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

Mr. ___ sustained a work related injury on ___, while employed with . He has received conservative care, diagnostics, medical consults and durable medical goods.

## Clinical Rationale

The documentation from the treating doctors, including the patient himself, stated that the stimulator made a clear difference in his pain levels. The documentation clearly followed the Texas labor code and offered a symptom relieving effect that is noticeable even on top of his other therapies, such as conservative care and prescribed drugs. That clearly separates this as a useful tool in this case. While it is debated in literature as to the effectiveness of these devices, this particular individual had documented

benefit from use of the device and has shown reduction in pain and improvement in function and activity level. This would warrant the purchase of the device, if the device is being effective in relieving his suffering and improving his function, as well as, any other treatment including medications, therapy, etc. Therefore, I believe the purchase of this muscle stimulator would be medically appropriate.

## 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

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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 27th 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.

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Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC:

RS Medical
Attn: Joe Basham
Fax: 800.929.1930

Hartford Ins.
Attn: Barbara Sachse
Fax: 512.343.6836

[Claimant]