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: M2-05-1758-01
RE: Independent review for ___

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

- Parker Healthcare Management received notification of independent review on 5.24.05.
- Telephone request for provider records made on 5.24.05.
- TWCC issued an Order for Payment on 6.7.05.
- The case was assigned to a reviewer on 6.9.05.
- 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 NMES unit

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

The records reflect that Mr. ___ is a 24-year-old gentleman who allegedly sustained injury to his lumbar and cervical spine while working at . He was injured when he was reportedly operating a hostler (this is a piece of equipment utilized to load freight onto trains.) He reports that on ___, the hostler was struck by a freight train and the vehicle was dragged at the tracks approximately 30 feet. He reportedly had a positive loss of consciousness and transient memory loss. There is not much in the way of a description of specific trauma that occurred other than the hostler was hit and he was in it. It does say that it was indicated that he was diagnosed with whiplash syndrome, thoracic strain and lumber strain with concussion.

Clinical Rationale

The rationale for overturning the carrier's denial is that the clinician documented specifically that this individual patient received significant medical benefit from the use of the device and demonstrated use of the device on a regular basis. Using the device improved his function and decreased his pain and increased his range of motion and ADL skills. The device was effective in helping him be more functional and the device reduced his visual analog pain scales. While there was no specific mention as to whether the device allowed him to take less medication, these devices are scientifically understood as to whether they provide significant benefit or not. While it is significantly debated in literature as to the effects of these devices, this particular individual has documented benefit from use of the device and has documented continuous 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. For these reasons, I believe it is imperative that this device be approved for this particular individual for these particular circumstances provided today.

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 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.

_____

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC:

[Claimant]

Specialty Risk Services
Attn: Julie Jansen
Fax: 972.807.4848