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

July 1, 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: M2-05-1771-01
RE: Independent review for ___

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

- Parker Healthcare Management received notification of independent review on 6.1.05.
- Telephone request for provider records made on 6.1.05.
- The case was assigned to a reviewer on 6.15.05.
- The reviewer rendered a determination on 6.29.05.
- The Notice of Determination was sent on 7.1.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity for a Lumbar Epidural Steroid injection at L5-S1

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**.**

Summary of Clinical History

Mr. ___ sustained a work related injury on ___, while employed with . He reported injuries to his mid to lower back.

Clinical Rationale

The medical literature only marginally supports the use of ESIs for radiculopathy with nerve root entrapment. The CT scan showed a central disc bulge at L3-4 and L4-5 but the neuroforamens were

clear. There was no focal neurological deficit reported by Dr. Rosenstein that correlates with the 10/23/03 CT scan. Thus, the necessity for this ESI intervention is not approved as a medical necessary.

Clinical Criteria, Utilization Guidelines or other material referenced

- Cuckler et al Journal of Bone and Joint Surgery 67A:63-66

This conclusion is supported by the reviewers' clinical experience with over 15 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 diplomate 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 1st 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:

Jacob Rosenstein, MD
Attn: Cheryl
Fax: 817.465.2775

American Casualty Co. c/o CAN
Attn: Deborah Womack
Fax: 214.220.5614

[Claimant]