

Parker Healthcare Management Organization, Inc.

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Certificate # 5301

July 11, 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: M2-05-1777-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 6.14.05.
- Faxed request for provider records made on 6.14.05.
- The case was assigned to a reviewer on 6.27.05.
- The reviewer rendered a determination on 7.7.05.
- The Notice of Determination was sent on 7.11.05.

The findings of the independent review are as follows:

Questions for Review

medical necessity of the cervical and lumbar myelogram CT scan.

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

Ms. ____ sustained a work related job injury ____, while employed with _____.

Clinical Rationale

Dr. Richard Guyer interpreted the lumbar MRI of 10.1.2003 and only noted a small disc protrusion that minimally compressed the thecal sac. There was no mention of any technical quality issues with this MRI. Thus, this study was of diagnostic quality. The reported L5 radiculopathy on the left side per Dr. Chris Tucker, is not consistent with the patient's physical examination or the L5-S1 small disc protrusion.

The cervical spine MRI performed on 9.27.03 was considered of fair quality by Dr. Guyer. Whether this study was done on an open MRI was not reported. This study showed a small right paracentral disk protrusion at C4-5 level, slightly compromising the C5 nerve root. Mild degenerative disc disease at C5-6, but neither the nerve root nor the thecal sac appeared compromised. Otherwise it was unremarkable. The necessity to perform a myelogram CT scan versus a repeat high quality MRI of the cervical spine is not medically established by these records.

Thus, the requested lumbar and cervical myelogram, which is an invasive study, is denied due to medical necessity for this study could not be established.

Clinical Criteria, Utilization Guidelines or other material referenced

- Spine Instructional Course Lectures 2003 American Academy of Orthopedic Surgeons.

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 11th 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:

American Home Assurance
Attn: Annette Moffett
Fax: 512.867.1733

[Claimant]